



## Overview


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

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

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

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

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

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 Administrator, Provider, Licensee, Field Manager (FM), Regional Administrator (RA) and Administrative Assistant (AA) can also refer to their designee.

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

- [Chapter 10.77 RCW Criminally Insane Procedures](#)
- [Chapter 13.36 RCW Guardianship](#)
- [Chapter 70.97 RCW Enhanced Services Facilities](#)
- [Chapter 71.05 RCW Behavioral Health Disorders](#)
- [Chapter 71.24 RCW Community Behavioral Health Services Act](#)
- [Chapter 74.34 RCW Abuse of Vulnerable Adults](#)
- [Chapter 70.129 RCW - LTC Resident Rights Statute](#)
- [Chapter 388-107 WAC Facility Licensing Rules](#)
- [Chapter 388-112A WAC Residential Long-Term Care Services Training](#)
- [Chapter 388-113 WAC Disqualifying Crimes and Negative Actions](#)
- [Chapter 246-215 WAC – Food Services](#)

RCS partners with the following state agencies and associations to develop ESF regulations and policies:

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

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](mailto:RCSPolicy@dshs.wa.gov) (**external** RCS use)[mailto:](#)
- [RCS Quality Improvement](#)



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## Part I: ESF Inspection Procedures

### A. General Guidelines

#### Purpose

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

#### Procedure

##### 1. Inspection Frequency

- a. RCS conducts unannounced inspections in ESFs at least every 18 months.
- b. The field manager (FM) must schedule facility inspections so that they are unpredictable with the average inspection interval being 15 months. This is achieved by:
  - 1) Inspecting a facility between 9-12 months if the facility has multiple, severe, or repeated compliance issues.
  - 2) Inspecting a facility between 16-18 months if the facility has few or limited compliance issues.

Note: The FM has authority to require early inspections if problems are identified.

##### 2. Inspection Procedures

- a. Follow the written inspection procedures and forms to ensure inspections are done in a consistent manner and focus primarily on actual or potential resident outcomes. Use observations and interviews to determine the facility's compliance with the licensing statutes and regulations. Begin making ongoing observations starting with the entrance, during the tour and throughout the entire inspection.
- b. When issues are identified, use record reviews to validate concerns identified by observation and interviews.
- c. Information can be collected off-site after the on-site inspection is completed if further information is necessary to determine and support non-compliance.
  - 1) The last date of data collection (LDDC) should occur within 20 working days of the exit date, unless there is documentation in the comment field in Secure Tracking and Reporting System (STARS) supporting the reason for the delay.
- d. Do not communicate about an issue too soon unless it is a serious issue that the facility must address immediately. Do not communicate issues that may lead to failed practice until you have collected enough information to make that determination.

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- e. Collect data from observations, interviews, and record review to support or invalidate an issue. Failed practice must be supported by at least two data sources.
  - f. Tell the administrator when they are in compliance with the regulations and when they have not met the requirements. The licensor may also tell the administrator if something the administrator plans to do would appear to help meet the regulatory requirements.
  - g. Do not provide technical assistance or best practice information on how to implement the regulations or correct the deficiencies.
  - h. Follow the current written standard operating procedures (SOP) and current [forms](#).
  - i. The inspection is unannounced; therefore, licensors will not disclose the planned date of the inspection to anyone (except the State Fire Marshal [SFM] if asked).
  - j. Licensors will attempt to minimize the disruption of resident and facility routines during the inspection.
3. Inspection Dress and Behavior:
    - a. Dress professionally.
    - b. Wear state identification badge.
    - c. Communicate with the administrator, staff, Ombuds, resident families, and residents in a courteous and respectful manner.
  4. Data Collection:
    - a. Data collection during inspections consists of observations, interviews, and record reviews and is:
      - 1) Collected in a factual and objective manner.
      - 2) Not affected by assumptions and personal opinions.
    - b. Timeliness of data collection:
      - 1) Collect data as quickly as possible.
      - 2) Collect data to support decision making for findings which could result in citations and enforcement.
      - 3) Delay in data collection may negatively impact the department's ability to cite or enforce.
  5. Resident Rights:
    - a. Monitor staff and residents throughout the inspection for resident rights including:
      - 1) Right to refuse.
      - 2) Choice.
      - 3) Dignity.
      - 4) Quality of life.
      - 5) Communication.
      - 6) Identified needs being met.
  6. Observations:
    - a. Are an important part of data collection.
    - b. By themselves, do not usually support a failed practice issue or concern and generally require additional observations, interviews, and record reviews to validate.

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- c. Are critical to either substantiate or rule out information obtained through record review and/or interview.
7. Field Manager Consultation:
  - a. Contact the FM for guidance if the following situations occur during the inspection:
    - 1) Something occurs that will likely extend the timeframe of the licensing visit.
    - 2) You are not sure how to proceed.
    - 3) Immediate enforcement may be needed.
    - 4) A nurse is needed for an inspection task and there is no nurse on the team.
    - 5) Someone is impeding the inspection.
    - 6) Residents appear to be alone in the facility or no one is in the facility.

Note: Staff may use [Attachment K: RCS Notes \(DSHS 15-581\)](#) at any time if needed. This is for additional notes and does not replace the need to document on the designated form.

### Field Manager Responsibility

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

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



### B. Pre-Inspection Preparation

#### Purpose

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

#### Procedure

1. During the pre-inspection preparation activities, identify residents for care and service issues that may be included in the resident sample.
2. Establish roles and responsibilities including a team coordinator.
3. Make copies or transcribe information from the licensing working papers that may be needed for the inspection.
4. Record all pertinent history, current data, and contact information on [Attachment A: Pre-Inspection Preparation \(DSHS 15-571\)](#).
5. Identify any issues related to abandonment, abuse, financial exploitation, or neglect.
6. Assemble the most current approved [forms](#) for recording data during the inspection.
7. Assemble supplies that may be needed prior to inspection.

Example: personal protective equipment, thermometer, dishwasher temperature strips, hair restraints, tape measure, calculator, paper/pen, and access to the RCWs and WACs pertaining to ESFs.

8. Review pertinent documentation on the facility history since the last full inspection:
  - a. Review the tracking system (such as STARS) and prepare facility summary.
  - b. Review tracking system for compliance history, number of licensed beds, specialty designations, contracts, current exemptions, and uncorrected citations since the last follow up inspection or complaint investigation.
  - c. Identify any reported changes to the facility since the last full inspection, such as change of administrator, change in ownership (CHOW), new construction projects approved by DOH, contract changes, or other information that would impact resident care and services. For new DOH construction project reports, go to: [Construction Review Search](#).
  - d. Review license for exemptions in STARS under the Exemption tab related to facility construction.
  - e. Review all Statements of Deficiencies (SODs) and enforcement actions since last full inspection for compliance history and identify deficiencies cited or consulted.

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- f. Identify and document, if applicable, any patterns of repeat and/or isolated deficiencies and resident identification.
  - g. Review the quality review complaints since the last full inspection.
  - h. Review [Infection Prevention and Control \(IPC\) Inspection tool \(DSHS 13-939\)](#) and identify and review National and State IPC standards, rules, and definitions applicable to the ESF setting. If there is an identified reported communicable disease outbreak in the facility, determine if Personal Protective Equipment (PPE) is needed.
9. Identify any open complaints yet to be investigated. Note resident and staff names and other contacts referenced in the reports as well as repeat issues or patterns.
  10. Review the State Fire Marshal's Office (SFMO) reports in the shared folder since the last full inspection for compliance history.
  11. Review the notes from the quarterly regional RCS/ombuds meetings in the shared folder and review any concerns brought up about the facility with the FM.
  12. Contact other field staff who were involved with the facility since the last inspection if an issue exists regarding compliance history, or if there are current issues in the facility.
  13. Contact FM if:
    - a. Special concerns exist that would require a licensed nurse, and none is available on the team.
    - b. Any questions or concerns arise after data collection.



### C. Infection Prevention and Control



#### 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 ESF licensing inspections.
  - 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 DSHS Form [IPC Inspection Tool](#) as a supplemental documentation tool when needed.
  - b. Completed DSHS Form [IPC Inspection Tool](#) **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 DSHS Form [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 facility.
- d. If a communicable disease outbreak is present in the facility, consult the Field Manager prior to initiating full inspection, and don appropriate PPE as directed or indicated.



### D. Entrance On-site

#### Purpose

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

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

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

#### Procedure

1. The team must vary the timing of the entrance (different days of the week, different times of the day) to increase unpredictability and to observe and capture different aspects of resident care.

Example: The team may enter after lunch and stay into the evening to observe dinner and care provided by evening staff, or the team may enter on different days of the week.

2. Entering the facility:
  - a. Enter the main entrance and go to the reception desk or lobby area to locate staff and make introductions. Inform them that a full inspection is occurring.
  - b. If the person at the entry is not the administrator, suggest they notify them of the full inspection. Explain that the inspection will not be delayed until the administrator arrives.
  - c. If no staff appear at the entry, evaluate the situation.
    - 1) If a resident answers the door or residents are observed from the entryway, make introductions, and inquire about staff in the facility.
    - 2) Do not complete the tour of the facility without staff or an administrator present. After the initial tour, field staff do not need to be accompanied by facility staff.
    - 3) If there is any evidence that residents may be alone in the facility, immediately contact the FM for further instructions.
  - d. If it appears no one (facility staff or residents) is in the facility:
    - 1) Check licensing information in pre-inspection preparation papers and call the listed phone number for the facility. If no answer, call any alternate phone numbers.
    - 2) Wait outside and try entrance again in 15 to 30 minutes.
    - 3) Contact FM is still unable to enter facility.
  - e. If denied entrance:
    - 1) Attempt to clearly re-state reason for visit.
    - 2) Suggest staff or resident contact the administrator if speaking to someone other than the administrator.
    - 3) Leave and immediately contact FM if still denied entrance.

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3. Upon entrance:
  - a. Make introductions to the administrator or staff and provide a business card. Have department nametag or state identification card visible throughout inspection.
  - b. Give the administrator or staff a reasonable amount of time to complete what they were doing before beginning the entrance conference.
  - c. Use any waiting time to observe the residents and the immediate environment, make introductions to any residents or staff in the area, and briefly explain the reason for the visit.
  - d. Request a place for the licensing team to work that does not intrude upon or interrupt the daily activities but provides an opportunity for ongoing resident observations. This place should include access to a power outlet and a means to secure belongings and/or RCS equipment.
  - e. Inform the administrator or facility staff that they can expect frequent contact from the licensing team during the inspection to gain and share information.
  - f. Remain aware of minimizing disruption of resident and facility routines as much as possible throughout the inspection. Adjust procedures of the inspection accordingly. However, do not delay the process. If unable to do a certain inspection task, use this time to do another task of the inspection before returning to the prior task.
4. Entrance Conference:
  - a. Review the inspection process and expectations with the administrator and staff.
  - b. Explain that the first step will be a guided tour of the facility as well as other areas accessed by the residents.
  - c. Request a facility contact person if the administrator will not be present at any time during the inspection.
  - d. Provide the administrator or staff with [Attachment B: Request for Documentation \(DSHS 15-572\)](#) and emphasize the timelines for requested materials.
  - e. The facility is not required to complete a DSHS form (unless directed through WAC). The facility can choose to provide the requested information on their own form(s).
    - 1) If the facility does not return the completed Attachment D: Resident Characteristics Roster and Sample Selection (DSHS 15-574) by the end of the tour, encourage use of the form by the following:
  - f. Verify the administrator knows how to access the form (online or by contacting the department).
  - g. Explain that the form serves as an informational tool for the facility staff by providing valuable information about each resident and their needs.
  - h. Explain that presenting the form in a timely manner helps speed along the inspection.
  - i. Ask the administrator or staff to describe any special features of the facility pertaining to resident care and services.

Example: Are there any changes since the last inspection? Anything new you would like us to know about?

5. Proceed with the tour.



### E. Tour



#### Purpose

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

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

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

#### Procedure

1. Tour the facility as a team with the administrator. The licensors may split the tour tasks (e.g., kitchen, laundry room, storage areas, etc.) among team members if facility staff other than the administrator are available who are knowledgeable about the building and residents. If the administrator or knowledgeable staff are not available, ask available staff to accompany and conduct the tour.
2. Communicate with the administrator throughout the tour regarding the features of the facility and request clarification related to observations or concerns as needed.
3. Conduct observations of residents, interior and exterior environments, staff/resident interactions, nursing services, and required posting of information.
4.  Document tour information on [Attachment G: Environmental Observations \(DSHS 15-577\)](#).
5. During the tour, licensors may refer to [Attachment C: Resident List \(DSHS 15-573\)](#) or the facility provided list for identification of residents and their room location, if available.
6. Use the observations and informal interviews during the tour to identify potential residents for the resident sample.
7.  Document observations as needed.
8. Observations During the Tour:  
The tour is the time to observe residents and their physical environment early in the inspection. If environmental issues are identified during the tour, licensors will have more time to conduct in-depth observations throughout the inspection. The following will be completed by the end of the tour:
  - a. Identify residents who express concerns or appear to have unmet or special care and service needs.

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- b. Determine if residents identified in the pre-inspection preparation are in the facility.
- c. Observe the general appearance of residents.
- d. Observe staff to resident interaction related to quality of life, dignity, privacy, and responsiveness to resident needs including verbal communication, eye contact, and touch.
- e. Observe residents' response to staff.
- f. Observe interior environment.
- g. Identify and conduct general observations of all areas designated for resident use including:
  - 1) Common areas for homelike appearance.
  - 2) Resident furnishings, beddings, walls, and floors for maintenance and cleanliness.
  - 3) Activity room(s).
  - 4) Laundry room(s).
  - 5) Storage areas, including medication storage.
  - 6) Restrooms.
- h. Observe for any safety hazards.
- i. Note presence of any lingering objectionable odors.
- j. Ask the administrator to explain how the 'resident-to-facility' communication system operates.
- k. Observe for adequate lighting necessary for safety and needs of residents.
- l. Observe for room temperature to determine if it is maintained at a comfortable temperature for resident living. If it appears very cold or hot in the building, continue collecting data including observing how residents are dressed and interviewing residents about the temperature.
- m. Observe general maintenance and housekeeping.
- n. Observe and inquire about resident or facility pets ([WAC 388-107-1610](#)) if facility policy allows.
  - 1) Verify pets are not permitted in central food preparation areas.

Note: Additional resources for trained service animals and emotional support animals can be found [here](#).

- o. Observe for safe storage of housekeeping supplies, including hazardous supplies and equipment (check Resident Characteristic Roster for known behaviors).

Example: If a resident does their own laundry, can they manage their own detergents?

- p. Observe hand-washing areas for staff and residents and observe whether staff are washing hands as required.
- q. Conduct initial kitchen tour and observe for general cleanliness and sanitation practices.
- r. Observe and inquire regarding any new construction or changes in the use of rooms in the facility to determine if DOH or DSHS review was required and obtained prior to construction or beginning use. Review the CRS approved plan to ensure it was implemented as approved. The CRS approved plan can be obtained by contacting the front desk of CRS.

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

Example: What is your name? How long have you lived here? What are you planning to do today? (Resident) or How long have you worked here? (Staff)

- d. Inform residents that if they have questions or concerns, they can discuss issues with the licensors during the inspection.

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### 13. Completion of tour:

- a. Thank the administrator for the tour.
- b. Obtain the completed [Attachment D](#), the facility generated staff list, and other documentation requested during the entrance conference.
- c. Inform the administrator that the team will be meeting briefly.
- d. Inform the administrator of next steps in the process.
- e. Inquire if the administrator has any questions at that time.



### F. Resident Sample

#### Purpose

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

#### Procedure

1. Review the completed [Attachment D](#) with licensing team.
2. Review information gathered for potential resident sample selection during the pre-inspection preparation, entrance, and tour.
3. Choose resident sample numbers in accordance with the Resident Sample Chart below. These are the minimum required reviews for the complete resident sample. If an additional issue is not identified, then the single or limited area review may not be necessary.

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

4. If a specific area of concern is identified during the inspection in facilities with seven or more residents, the sample must be expanded by three to investigate single or limited areas of concern (refer to Resident Sample Chart). If the scope of the problem is adequately identified within the current sample, the expanded sample is not necessary.
5. Refer to [Attachment D](#) and information obtained through observations and interviews to ensure the resident sample represents as many of the applicable categories identified below as possible:
  - a. Interviewable and non-interviewable.
  - b. Medically fragile ([WAC 388-107-0260](#)).
  - c. State funded.
  - d. Receive basic services such as help with activities of daily living.
  - e. Have special dietary needs or significant weight changes.
  - f. Require medication assistance.
  - g. Have special or unmet needs or are potentially vulnerable for abuse.


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Example: Residents with dementia, delusional thought process, infrequent visitors, behavioral issues, non-English speaking, hearing, and vision impaired and/or require high level of care (e.g., residents with chronic conditions, such as diabetes).

6. Make efforts to include residents who have not been in a previous inspection sample.
7. The administrator and facility staff may be an important source for obtaining additional information on the selected resident sample.
8. Sample Substitutions
  - a. Adjustments can be made to the resident sample in the following situations:
  - b. If the team finds it necessary to remove a resident from the sample, such as:
    - 1) Resident declines to be interviewed or observed.
    - 2) Resident is not available during the inspection.

Note: Interviews must be conducted with each sampled resident or their representative. If unable to complete the interview with the resident or representative, substitute with another resident and document the reason for the substitution.

- c. If a specific area of concern is identified during the inspection in facilities with seven or more residents, the sample must be expanded by three to investigate single or limited areas of concern (refer to [Resident Sample Chart](#)). If the scope of the problem is adequately identified within the current sample, the expanded sample is not necessary.
- d. Any substitution should be with a resident who best fulfills the reason the first resident was selected.
- e. Don't assume a resident is unable to be interviewed. Verify it for yourself after various attempts.
- f.  If a resident is substituted, document the reason for the substitution.

Example: Your initial sample included a resident with diabetes who chose to decline an interview. You substituted with another resident with diabetes. Sample working paper documentation: "Resident A declined interview, substituted with Resident Q who has similar care needs."

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





### G. Interview

#### Purpose




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

#### Procedure

1. Interviews will include the following individuals:
  - a. Residents:
    - 1) Sample residents.
    - 2) Residents are the best point of contact when gathering data on resident quality of life and care.
    - 3) If a resident has difficulty communicating, consider interviewing at another time or through alternate methods such as in writing or using an interpreter (see [Resources](#) for more information).
    - 4) A resident has the right to choose not to interview. In this event, substitute with another resident as addressed in the [Resident Sample](#).
      - a)  If a resident is substituted, document the reason for the substitution.
    - 5) Throughout the inspection, the licensing team should be available for contact by any resident requesting to talk to them.
  - b. Facility staff: administrator, MHPs, nursing staff, caregivers, other staff working at the facility, and volunteers. Licensors may use [Attachment J: Staff Interview \(DSHS 10-703\)](#) to guide interviews.
  - c. Other contacts: family members or resident representatives, outside resources or agencies including case managers, health care practitioners, home health/hospice, law enforcement, and other contacts not associated with the facility.
2. Formal Interviews
  - a. Conduct formal interviews with all sampled residents.
    - 1) Review the person-centered service plan (PCSP) briefly prior to conducting the sample resident interview.
    - 2) Address all categories in [Attachment E: Resident Interview \(DSHS 15-575\)](#). As much as possible, let the resident lead the interview.
3. Choose the best location for interviews considering:
  - a. Privacy (including ensuring that monitors and intercoms are turned off).
  - b. Comfort and accommodation of the person's needs.
4. Interview a family member or resident representative when a sample resident is not interviewable, cannot give reliable or sufficient information, or their interviewing capability is limited due to issues that impair communication such as speech impairment, confusion, delusion, or dementia.
  - a.  If a representative is substituted, document the reason for the substitution.

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5. Obtain the services of an [interpreter](#) if the resident sample includes a non-English speaking resident. This may require a scheduled return visit. Notify the FM early in the process if an interpreter is required for a sampled resident.
6. Interview others involved in the resident’s care and services such as parole officer, case manager, ombuds, advocacy groups, etc., to obtain information that is necessary to support a citation.
7.  Document IPC interviews on the [IPC forms](#).
8. Process:
  - a. Use pre-inspection preparation information, observations and informal interviews conducted during the tour, and a brief review of the person-centered service plan to supply information and points of discussion for the interview with the sample resident, facility staff, or other contacts.
  - b. Introduce yourself to the resident and briefly explain the reason for the interview and the inspection process.
  - c. Let the resident know their right to choose not to be interviewed and the inspection team’s need to take notes during the interview in order to be accurate.
  - d. Inform the resident that notes taken during the interview may be used in the future. Explain that confidentiality cannot be guaranteed and that there may be circumstances when the department must share information.
  - e. Let the interviewee lead the interview.
  - f. Use open-ended questions and active listening skills for all interviews. Speak slowly and clearly.
  - g. Use quotation marks when quoting what the resident says they feel, e.g. “I feel”, or “It makes me feel.” Quotations can have a major impact in the SOD.
  - h. Address any statements that appear unclear or need further explanation.
  - i. Observe the resident and their environment during the interview.
  - j. If the resident gets tired before the end of the interview, complete the interview later.
9. Interview Conclusion:
  - a. Allow the interviewee to ask questions and provide any additional information.
  - b. Provide a contact number.
  - c. If a follow up interview is anticipated, inform the interviewee that they may be contacted again and inquire as to their availability.
  - d.  Complete documentation of interview. Notes must support any compliance determination.
  - e. If quoting anyone, make sure it is verbatim.
10. Informal Interviews:
  - a. Conduct informal interviews with residents, visitors, administrator, and staff throughout the inspection.
  - b. If an issue is identified, conduct an in-depth interview about the issue using [Attachment E](#).
11.  Document the information from the interviews using attachments as a guide.
  - a. Sample resident interview: [Attachment E: Resident Interview \(15-575\)](#).
  - b. Other contact interview: [Attachment F: Other Contact Interview \(DSHS 15-576\)](#).
  - c. Staff Interview: [Attachment J: Staff Interview \(DSHS 10-703\)](#).





### H. Observation of Care

#### Purpose

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

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

#### Procedure


1. Conduct observations of residents at all times during the inspection and document observations and issues regarding resident outcomes (actual or potential).
2. Conduct observations targeted to care issues of residents when a specific care issue has been identified. For these observations:
  - a. Observe, if possible and with resident's permission, the caregiver providing assistance with personal care.
  - b. Do not touch or examine a resident or provide hands-on care. Request facility staff to provide the direct care if the resident agrees.
3.  Document observations including description of observation, resident name, caregiver name, date, time, and location of observation. Documentation may be done on any of the appropriate forms ([Attachment E](#), [Attachment G](#), or [Attachment K](#)).
4.  Document IPC observations on the [IPC forms](#).
5. Collect additional data that may be required to support, clarify, or invalidate the observations.

Example: A resident is observed to have long, dirty fingernails. Further data collection included an interview with caregiver who relayed the resident was refusing fingernail care.

6. RCS registered nursing staff will conduct all observations that require looking at a resident's breasts, genitalia, and buttocks.
7. Data Gathering for Observations  
Residents may be identified for potential observation of care through any part of the inspection including the pre-inspection preparation, on-going observations and interviews with residents, staff, and outside contacts:

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- a.  Document any care issues noted during the licensing file review and interviews (e.g., a resident mentioned in a recent complaint report or identified as having care issues by the case manager).
  - b. Note any residents who express problems or concerns or those residents who appear to have unmet care needs.
  - c. Review of [Attachment D](#) and interviews with residents, facility staff and outside contacts may also identify care issues requiring observations.
8. Make observations of residents throughout various times and locations of the inspection to provide a more complete perspective of the resident’s engagement in services and activities at the facility. Consider hourly rounds to support a compliance condition that needs a longer observation period for documenting an apparent issue that may impact the resident consistently throughout the day.

Example: residents who have fall histories could be observed at several times throughout the day to see if they have mobility assistive devices nearby.

9. A resident has the right to choose not to be observed. In this event, substitute with another resident as addressed in the [Resident Sample Selection Process](#).
10. Observations of the resident’s general appearance can occur at any time during the inspection. Consider:
  - a. Personal hygiene including oral hygiene, grooming, body odors, nail and hair care, clean and intact clothing.
  - b. Visible skin condition.
  - c. Behavior issues and level of cognition.
  - d. Mobility.
  - e. Functional risk factors such as positioning, vision or hearing deficit, side rail use, restraints.
  - f. Appropriate clothing for season, dignity, and comfort.
  - g. Shoes or other footwear appropriate for safety, comfort, or therapeutics.
  - h. Mobility devices in good repair, clean and functional, and used as medically authorized.
11. Observations specific to a resident or care issue may require a more structured and planned setting for the observation. Observe for the following:
  - a. Resident response to the care provided:
    - 1) Resident behavior.
    - 2) Resident level of comfort.
  - b. Observe staff interacting with resident(s).
  - c. Observations of the MHP may include:
    - 1) Providing and documenting direct service to residents.
    - 2) Utilizing de-escalation techniques if needed.
    - 3) Discussing and implementing behavioral support plans.
    - 4) Providing education and assistance to caregiving staff regarding behavioral interventions.

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- d. Observations of caregiver or nursing staff performing care may include:
- 1) Staff to resident interaction.
  - 2) Appropriate infection control practices.

Example: when using “Point-of-Care” devices such as finger-stick devices and blood glucose meters.

- 3) Assistance provided as identified in the PCSP.
- 4) Physical care provided using safe and appropriate techniques.
- 5) Inclusion of resident’s participation in care tasks to the maximum of their ability as identified in the PCSP.



### I. Abuse/Neglect Prevention Review

#### Purpose

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

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

Note: For definitions of abuse, refer to [RCW 74.34.020](#).

#### Procedure

Field staff will:

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

Note: See [Resources](#) for specific examples of potential abuse, link to [Key Triggers](#) which may indicate abuse, and sample questions to ask during interview.

3. During administrator and staff interviews, verify understanding of abuse and what to do if abuse is suspected or witnessed. This includes staff understanding of:
  - a. Financial exploitation, physical, mental, and sexual abuse.
  - b. Steps to take in the event of suspected abuse.
  - c. Notification and reporting requirements as described in the ESF’s policies and procedures.
4. Request the facility’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 abuse reporting law; 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 field staff’s first responsibility is as a mandated reporter.

Field staff will:

  - a. Immediately notify the CRU by [email](#), with a cc (carbon copy) to the FM.
  - b. Contact the FM if any of the following situations occur:

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- 1) If possible resident abuse or neglect is occurring during the visit.
  - 2) If the investigation will extend the timeframe of the licensing visit.
  - 3) If unsure how to proceed.
  - 4) If investigation should be conducted immediately.
  - 5) If immediate enforcement may be needed.
  - 6) If a nurse is needed and a nurse is not on the team.
  - 7) If law enforcement (LE), Adult Protective Services (APS), or both should be notified for purpose of conducting a joint investigation.
- c. Immediately notify LE if:
- 1) There is reason to suspect sexual assault has occurred.
  - 2) There is reason to suspect physical assault has occurred.
  - 3) There is reasonable cause to believe that an act has caused fear of imminent harm.

Note: 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:

- Requested by the injured resident/legal representative or family member;
- The injury appears on the back, face, head, neck, chest, groin, inner thigh, buttock, genital or anal area;
- There is a fracture;
- There is a pattern of physical assault between the same residents; or
- There is an attempt to strangle a resident.

- d. Verify resident(s) safety before conclusion of the on-site visit.
- 1) FM Responsibility: Ask the administrator to submit a written 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.

Note: This should only be done with FM and/or Regional Administrator (RA) approval.



## J. Medication Services

### Purpose

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

### Procedure


1. Review the medications for the sampled residents during the resident record review.
2. Contact the FM to determine if a Registered Nurse (RN) needs to join the team to complete the medication review, observe the medication pass, or if an issue is identified.
3. Review medication services including:
  - a. Medication storage: safety, labeling, organizers.
  - b. Medication delivery system: documentation, assistance/administration, alterations, suitability for resident needs.
  - c. Medication prescriptions received timely.
  - d. Respect of resident rights: right to refuse, individual choice and preference.
  - e. Disposal of medications.
4. General observations of medication services should occur throughout the inspection. Licensors may use [Attachment Q: Medication Observation \(DSHS 15-603\)](#) as a guide and document any areas of concern to follow up on during the medication services task.
5. Observe medication storage area throughout the inspection for the following:
  - a. Medications are secure for residents not capable of self-storage.
  - b. Medications are properly labeled.
  - c. Medications for a specific resident are stored together and are kept separate from other resident medications, food, and toxic chemicals.
  - d. Storage area is locked and accessible only to designated staff.
  - e. Medications are stored according to medication label recommendations.

Example: “keep refrigerated.”

6. Observe staff during medication assistance and administration throughout the inspection for the following:
  - a. Staff knowledge and technique.
  - b. Staff-to-resident interaction and communication.
  - c. Appropriate level of medication assistance and administration.
7. Complete record review of general medication system.
8. Interview residents regarding medication services.

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9. Interview staff regarding medication storage, including:
  - a. System for controlling and securing medications for residents assessed to be capable of self-administration or self-administration with assistance.
  - b. Use of medication organizers.
10. Observe resident room during interview for medication issues such as medications on floor or inappropriately stored.
11. Review medication records noting any documentation of refusal or no availability of medications, if the physician was notified of a refusal, and if appropriate action was taken if there was a pattern of refusal (for pattern of refusal see [WAC 388-107-0350](#)).
12. Conduct resident record review noting if the PCSP addresses medication.
13.  Staff may use [Attachment Q](#) as a guide while conducting medication observations. If a concern comes up during medication observations, conduct observations of a medication pass and document on [Attachment N: Medication Pass Worksheet \(DSHS 15-584\)](#). During medication pass observations:
  - a. Compare observations with the prescriber's orders.
  - b. Review the medication records for accuracy and completeness.
  - c. Review if the facility reconciles and secures controlled medications.
  - d. Observe whether staff confirmed the resident's identity prior to giving medications.
  - e. Record procedures staff use to handle and administer medications.

Example: flushing gastric tubes, crushing medications, injecting diabetic insulin.

- f. Identify medications not being given in a timely manner.
- g. Review how emergency medication issues are handled.

Example: allergic reaction, incorrect medications given, overdose.

- h. Review what the facility does to obtain medication in a timely manner.
- i. Consult with an RCS RN if clinical questions arise.

Note: If allied health staff identify an issue not within their scope of knowledge or duty in areas such as administration of health treatments, tube feeding, non-routine ostomy or catheter care, they will consult with an assigned nurse or the FM for direction.

14. Review medication orders for all sampled residents with the logs to verify residents are receiving all medications and supplements as ordered. When a medication count is needed, the facility staff must handle all medications. A guide on how to reconcile medications can be found [here](#).
15. If an issue is identified, expand the sample to include supplemental residents per guidance in [Resident Sample](#).




### K. Environmental Observation

#### Purpose

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

#### Procedure

1. Conduct observations regarding the appearance of the facility throughout the inspection.
2. Conduct observations of an open resident room, if resident permits, during the tour and during a resident interview.
3. Share observations with the licenser responsible for conducting and coordinating the environmental observations.
4. Conduct observations in the common areas.
5.  Document findings of environmental observations using [Attachment G](#). If additional space is needed, use [Attachment K](#).
6. Check water temperature in resident utilized bathrooms ([WAC 388-107-0970](#)).
7. Conduct observations of common areas and resident rooms including the following:
  - a. Information posted: contact for department hotline and Ombuds hotline.
  - b. Interior environment homelike and clutter free.
    - 1) Homelike refers to avoiding an institutional setting appearance and can include furniture, decor, and recreational materials.
  - c. Access to secure, covered outdoor area.
  - d. Maintenance and housekeeping – Interior.
  - e. Quality of life.
  - f. Safety issues.
  - g. Safety and disaster preparedness.
  - h. Exterior environment.
  - i. Sufficient space to accommodate residents in common areas.
8. Review STARS for exemptions related to facility construction prior to observations.
9. Consult with the administrator and staff if you need any clarification of observations of the environment.
10. If smoking is permitted for residents, check that the facility has identified a safe area 25 feet from the building per [Chapter 70.160 RCW](#).

Note: per care plan, smoking supervision may be required.

11. If electronic monitoring (audio or video) is used, ensure adherence to [WAC 388-107-0780](#) and [WAC 388-107-0790](#).

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12. Maintain open communication with all members of the team if you identify clinical or nursing care issues during the environmental observations to ensure that issues are not systemic.

Examples: wound care, incontinence care, pressure sore, injury.

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





### L. Food Services

#### Purpose

The purpose of food services is to provide the licensor with an overview of the ESF food service operation to include risk-based inspection criteria which consists of staff knowledge of Food Borne Illnesses (FBI); how food is prepared, handled, and stored; how equipment and food contact surfaces and utensils are sanitized; and an overview of dining services and meal planning to meet residents' dietary needs.

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

#### Procedure

1. Use the tour as the first opportunity to observe the food service environment and general food service practices including proper food handling skills and hand washing.
2. For all residents in the sample with diet related concerns:
  - a. Interview and observe the residents regarding meals and food services, individual nutritional needs, preferences, and reasonable accommodations including, but not limited to, modified or therapeutic diets or feeding tubes.
  - b. Review resident records for prescribed or non-prescribed nutrient supplements or modified or therapeutic diets.
3. Conduct interviews and observations regarding food services with residents in the sample.
4. Conduct record reviews specific to food services for sample residents only if an issue has been identified.
5.  Document on [Attachment I: Staff and Administrative Record Review \(DSHS 15-579\)](#) the food handler cards for sample staff. If a resident is routinely involved in the preparation of food to be served to other residents, or as part of an employment-training program through Supportive Employment with Home and Community Services, request a food handler card.
6. Conduct observation of food services for high risk factors to ensure a risk-based inspection is conducted and proper control measures are in place.
7.  Complete [Attachment M: Food Service Observations and Interviews \(DSHS 15-583\)](#) in accordance with [WAC 246-215-08430](#).
8. Wear a hair restraint if applicable throughout the kitchen inspection in accordance with [WAC 246-215-02410](#).

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9. Observe food safety to include personal hygiene, employee health, time and temperature control, and potential cross contamination during food preparation and service.
10. If concerns are identified, conduct further observations and interviews with residents.
11. The licensor responsible for the food service task will make introductions to food service staff, conduct informal interviews, establish which staff is the contact, and briefly explain the food service task to facility staff.
12. Other members of the team will share general observations with the licensor responsible for conducting the food service task.
13. Food services will include the consideration, through the sample residents, of individual resident needs such as:
  - a. Preferences.
  - b. Alternate choices.
  - c. A system for residents to express their comments on food services.
  - d. Prescribed diets.
  - e. Prescribed nutrient supplements and concentrates.
  - f. A variety of daily food choices.
  - g. Temperature of food.
  - h. Assistance with eating if applicable.
14. There is no need to routinely check the temperature of food. However, if a resident complains about food temperature or if you see prepared food sitting for long enough to impact the appropriate temperature of the food being served, check the temperature just before it is served to residents.
15. Interviews with residents, administrator, caregiver staff, collateral contacts, and food service staff are important sources of information.
16. Observation of a meal may require an adjustment in the inspection schedule to allow time for the observation.
  - a. If a meal is occurring at the time of entrance or tour, field staff will conduct general observations if more opportunities will occur later in the inspection.
  - b. If no other meal observations will occur, or many residents will be out of the facility during other meals, the team coordinator will inform the administrator that the entrance conference or tour will be postponed in order to conduct a meal observation at that time.
17. Dining Observation:
  - a. Conduct meal observation while sitting, if possible, to avoid standing over the residents. Be aware that documenting during observation can impact resident comfort.
  - b. Observe dining area for adequate seating capacity (75% or more residents per meal setting).
  - c. Observe for timeliness of meal service.
  - d. Observe for sufficient time and staff to meet resident needs.
  - e. Observe meal for attractively served meals that are nourishing and palatable.
  - f. Observe any sample residents who require eating assistance.
18. Identify sample residents who are currently receiving meals in their room, noting the reason and if the meals are assisted per care needs.




### M. Resident Record Review

#### Purpose



The purpose of resident record review is to collect and review documented data in the ESF to determine if resident care and service needs are being met. Any concerns identified during the record reviews must be followed-up on with interviews and/or observations to determine failed practice.

#### Procedure

1. Conduct a complete resident record review for residents in the sample.
2.  Use [Attachment H: Resident Record Review \(DSHS 15-578\)](#) to document information including:
  - a. Resident assessment.
  - b. Monitoring of resident's well-being.
  - c. PCSP.
  - d. Medication record and other information.
  - e. Behavioral Support Plan (this document may be incorporated with care plan).
3. For all sample residents, gather information from the record review to support or validate issues identified during observations and interviews.
4. Determine if information obtained from record review will require further interviews and observations.
5. Observations and ongoing communication with the facility staff continue throughout the record review process. However, issues that may lead to a failed practice should not be communicated until sufficient evidence is collected, unless it represents an immediate danger to a resident or residents.
6. If information regarding assessment issues has been identified, the licensor should review the qualified assessor qualifications.
7. Expanding record review:
  - a. If necessary, conduct a single or limited area record review of expanded sample residents (see [Resident Sample](#)). A record review for expanded sample residents is not a routine process and should only be done if necessary to make a compliance decision. It is driven by a specific issue or concern identified during observations, interviews, and record reviews of in-depth sample residents.
  - b. Expand the documentation review beyond six months only when an actual or potential outcome requires further history.
8. When to review a facility record:
  - a. Review of additional documentation kept by the facility may be required to complete data collection regarding a specific issue.

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- b. Facility documentation that may need to be reviewed if further information is needed to determine compliance include:
  - 1) Incident/accident documentation.
  - 2) Policies and procedures.
  - 3) Financial records only as they are related to resident care or services not being met.
  - 4) Quality Improvement (QI) Committee notes (only for the information necessary to determine the existence of a QI committee and that it is operating in compliance with the regulations, or if the licensee offers the QI committee records as evidence of compliance) ([WAC 388-107-0220](#)).
- 9. When to review a closed resident record:
  - a. Review a closed resident record when an issue is identified that directly relates to a specific resident no longer in the facility, if no current residents reside in the facility, or if there is a concern regarding discharge or transfers.
  - b. If no specific resident has been identified but a concern regarding discharge or transfer has been determined, review the resident register for recent discharges.
  - c. Interviews with other residents and staff may also assist in selecting the closed record; therefore, selection of the closed record may occur later in the process.
  - d.  Review record for identified concern and document using [Attachment H](#) or [Attachment K](#).
  - e. Obtain a name and contact phone number of the legal representative if necessary to determine facility compliance.
  - f. Obtain a name and contact phone number for the healthcare practitioner, case manager, and other supports if necessary to determine facility compliance.
- 10. When to review other records:
  - a. Review of outside records, such as hospital records, police records, agency records, and other records not associated with the facility will rarely be done and only when necessary to determine failed practice.
    - 1)  Document a contact name and number or address regarding outside record on [Attachment F](#).
    - 2) Verify with the resident or facility staff to ensure the contact information is accurate.
    - 3) Initiate the review of outside records (written request, on-site visits, fax, or phone) as soon as possible. The inspection is not complete until the last date of data collection.



## N. Facility Staff Sample and Record Review

### Purpose

The purpose of facility staff sample and record review is to select a staff sample and to determine whether the ESF has a systematic and consistent way to ensure that staff meet the statutory requirements for training, certification, experience, qualifications, and credentials to provide the care and services required for the residents in the facility.

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

### Procedure



1. Request a staff list at the entrance conference using [Attachment B](#).
2. Select the staff sample at the team meeting. Selection criteria for facility staff sample:
  - a. If the ESF has changed administrators since the last inspection, review the administrator's records to ensure they meet the appropriate qualification and training requirements.
  - b. Review staff list for hire dates and titles:
    - 1) Select three employees who have been hired in the period since the last inspection and conduct a full review of training and other requirements and qualifications. If fewer than three were hired, review records for all new employees.
    - 2) If there have been no new hires since the last inspection, select three staff who were not reviewed during the previous inspection.
    - 3) In addition, conduct a targeted review of two staff (this could include the administrator) with a work history of over two years at the facility. The intent of the review is to verify that a system is in place to conduct background re-checks, meet continuing education (CE) requirements, and renew any certifications that expire.
    - 4) A minimum of four staff should be reviewed.

Example: Select three new staff for the full review. When selecting the sample for the targeted review, licensors may select two staff with a >2-year work history *or* an administrator with >2-year work history and one staff with >2-year work history. If there are not enough current staff with >2-year work history, licensors may use former staff.

3. Provide the list of required staff records to the administrator. Allow adequate time for facility staff to provide requested documents before the review.
4. Review staff records for required training, credentials, screenings, and other qualifications as it pertains to their job requirements.

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5.  Document on [Attachment I](#).
6.  Document IPC record review on the [IPC forms](#).
7. Refer to Training Requirement grid [WAC 388-112A-0070](#) for additional information regarding ESF training requirements.
8. Review the facility emergency disaster plans including annual staff training ([WAC 388-107-1600](#)).
9. Expand the sample if there are identified concerns about training and other requirements for facility staff. The expanded sample can help determine if the issue is isolated or systemic.

Note: Facilities must conduct background checks for volunteers, managers, and contractors. Licensors may request and review these records during focused reviews.

10. Use interviews and observations to identify possible or actual negative outcomes to residents related to staff training or qualifications.
11. If issues related to quality of life or provision of care and services were identified during the observations and interviews that may indicate the employee's lack of training or qualifications, review records for pertinent information.
12. Criminal history background checks and related sensitive and confidential information should never be included in the working papers. Review these documents while in the facility and document details in the working papers.
13. Review pet records when applicable to verify certification by a vet to be free of diseases and are up to date on examinations and immunizations. If the facility has three or fewer pets, review all pet records. Identify a random sample of three pets when the pet population exceeds three.
14. Communicate findings of incomplete or outdated information to the administrator to provide the opportunity for them to submit any outstanding documentation.
15. A record review alone may not provide enough information to confirm or disprove a deficient practice. Further data collection from interviews or observations may be necessary.

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### O. Facility Staff Schedule and Staffing Levels Review

#### Purpose

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

The ESF is responsible for maintaining staffing levels as outlined in [WAC 388-107-0230](#) and [WAC 388-107-0240](#).

#### Procedure

1. During the entrance, request working schedule of care staff, nursing staff, MHPs, and on-call RNs and MHPs for prior two weeks using [Attachment B](#).
2. Conduct a complete review of staffing schedule as actually worked.
3. Discuss with the administrator any gaps in coverage and, if needed, request additional proof of staffing coverage such as timecards.
4. If staffing issues are identified, request one or two additional staff working schedules from the past 90 days and conduct a complete review of the working schedule.
5.  Document information on [Attachment O: Staff Schedule Worksheet \(DSHS 15-585\)](#).
  - a. Licensors may use [Attachment O2: ESF Staff Schedule Worksheet: 8-hour Shifts \(DSHS 15-585A\)](#) or [Attachment O3: ESF Staff Schedule Worksheet: 12-hour Shifts \(DSHS 15-585B\)](#) to help determine if required staffing levels are met.
6. A record review alone may not provide enough information to confirm or disprove a deficient practice. Further data collection from interviews or observations may be necessary.



### P. Exit Preparation

#### Purpose

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

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

#### Procedure

1. Communicate with the administrator and facility staff throughout the inspection to facilitate complete data collection and to ensure no “surprises” at the exit conference.
2. Notify the administrator when the on-site inspection tasks have been completed and the RCS team is meeting for the exit preparation.
3. Schedule the exit conference with the administrator and invite the Ombuds and interested residents to attend. Contact the Ombuds as early as possible to let them know when the exit is scheduled.
4. Conduct a team meeting to review identified concerns based on observations, interviews, and record reviews and to determine deficient practice.
5. Facilitate the exit preparation and organize the information to be presented using [Attachment L: Exit Preparation Worksheet \(DSHS 15-582\)](#) in a manner that can be clearly understood by the administrator and the Ombuds. List the issues in order of severity with most serious issues presented first and consultations last.
6. Review information and deficiencies and identify any negative resident outcomes or the potential for a negative outcome using specific residents from the sample when possible. If residents will be present for the exit or have requested that their issues be kept confidential, ensure confidentiality is maintained to the extent possible.
7. Conduct the exit preparation in a setting that is on-site and confidential.
8. Exit preparation may not be the final determination of compliance. Further analysis and data collection may continue after the on-site visit including collateral contact interviews, collateral record review, and review of documentation.
9. Decide if further information will be required after the exit and identify the licensor responsible for that data collection.




### Q. Exit Conference

#### Purpose

The purpose of the exit is to provide the ESF with the results of the inspection and to provide the administrator an opportunity to present additional information. The exit conference occurs at the end of the on-site inspection and is conducted with the RCS licensing team and the administrator. Other attendees may include ESF staff, the ombuds, residents, and resident's representatives as observers.

The exit conference is held in a private setting in the facility, observing confidentiality and encouraging dialogue.

#### Procedure

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



### R. Off-site Activities

#### Purpose

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

#### Procedure

Licensors will:

1. Determine if additional interviews or record reviews outside the ESF 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.

- a. All contact attempts should be completed within 20 working days of the exit date, unless an extension has been approved by the FM.
- b. Make a minimum of three attempts to reach outside contacts and document the date and time of attempts on [Attachment F](#).

Note: Interviews with resident representatives or family members completed when a resident is not interviewable should be documented on [Attachment E](#).

2. Save electronic documents to the office shared files using the standardized naming guidelines outlined in the [Electronic Document Naming Key](#).
3. Review and analyze all data collected after exit to make final determination of failed practice.
  - a. If failed practice is identified, the findings will be documented in detail within the SOD based on identified rules and regulations.
4. Coordinate any enforcement recommendations with the FM ([SOP Chapter 7: Enforcement](#)).
5. Create the [Confidential ID list \(DSHS 27-238\)](#) using the standardized template and include a copy when sending the SOD.
6. Complete data entry in STARS.
7. Notify the administrator if:
  - a. Information in the SOD is different from what was communicated during the exit conference (including additions, deletions, or changes).
  - b. There are delays in completion of the SOD.
8. Document the pertinent details of the call including the time, who the meeting was with, and information relayed to the provider.
9. Use the standards outlined in [SOP Chapter 18: Across All Settings](#) when writing the SOD if applicable.

The FM will:

1. Discuss with licensors if any enforcement actions will occur and follow process for enforcement ([SOP Chapter 7: Enforcement](#)).



## S. Follow Up Visits

### Purpose

The purpose of the follow up is to determine if the ESF corrected the regulatory violations and deficient practices cited in the SOD. The visit should focus only on previously identified deficiencies not yet verified as corrected.

### Procedure

#### FM responsibility:

1. Coordinate scheduling for follow-ups. If possible, include at least one person that was on the previous visit.
2. Identify how the follow-up will occur using these criteria:
  - a. On-site:
    - 1) Deficiencies involve a negative or potentially negative resident outcome, or
    - 2) Deficiencies require observation to determine compliance, or
    - 3) Documentation submitted by the entity for an off-site follow-up does not adequately support the conclusion that correction has been achieved, or
    - 4) After a finding of a violation for which a stop placement has been imposed, within 15 working days from the request for follow up, or
    - 5) The FM determines this would be the best method.
  - b. Off-site:
    - 1) The deficiencies are not associated with an actual or potentially negative resident outcome, and
    - 2) The deficient practice issue is such that there are clear, objective criteria for determining compliance, and
    - 3) A review of the last 36 months shows a history of compliance.
    - 4) The method used for the off-site visit is at the discretion of the FM (e.g., phone, email, or video calls).

#### Timelines:

1. When planning the date for the follow up visit, consider how much time is needed to allow for the provider to be able to demonstrate compliance. Follow-up timelines are at the discretion of the FM. However, the following timeline is recommended:
  - a. 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.
  - b. Follow up due date – requirement 1 (15 day): Follow up must be initiated within 15 calendar days from the latest date the ESF has listed on the Attestation unless the FM approves an extension.
  - c. 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.

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- d. 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.

- e. If there is a stop placement, discuss the follow-up timeline with enforcement.

**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 entity has indicated the deficient practice will be corrected (POC Date). In the example scenario, the entity has two deficiencies with different correction dates. The timeline below demonstrates how this would be mapped out:

```
graph TD; D0[Day 0: 02/01/2024 (LDDC)] --- D1[Day 1: 02/02/2024]; POC1[POC Date 1: 03/10/2024]; POC2[POC Date 2: 03/13/2024]; L15[15 days from latest POC date: 03/28/2024 Latest date to initiate follow-up]; D45[Day 45: 03/17/2024]; D60[Day 60: 04/01/2024 Date follow up must be completed Extension requires documented FM approval]; D0 --- POC1; D0 --- POC2; POC1 --- L15; POC2 --- L15; L15 --- D45; L15 --- D60; D45 --- D60;
```


The licensor will:

1. Consider the following prior to the follow up:
  - a. Current deficient practice issues, including the nature, scope (number of residents impacted or potentially impacted), and severity (seriousness or extent of the impact or potential impact on resident) of the deficient practice of each cited deficiency.
  - b. The enforcement remedies imposed as a result of the inspection.
2. Only do the inspection tasks necessary to determine if the deficient practice has been corrected.
3. Base the sample size on the number of residents necessary to determine compliance, focusing on residents who are most likely to be at risk of issues resulting from the deficient practice cited in the original SOD.

Example: Usually more than one resident in the sample is needed to have enough information to determine compliance. Best practice is to include at least one resident from the original sample and at least one previously unsampled resident.

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4. Only review information from the time between the last date on the POC and the date of the follow-up to determine if the deficient practice has been corrected and the ESF is back in compliance.
5.  Indicate in STARS if the facility was found to be back in compliance.


### For off-site follow up:

1. The licensor will call the ESF when it is appropriate to conduct an off-site follow up. The licensor can specify what documentation may be acceptable to submit as evidence.
2. ESF sends evidence of compliance, fully addressing necessary actions taken by the facility to correct deficiencies; including how and when the correction was achieved. Submitted documentation must show the facility is back in compliance for each deficiency.

Examples: CPR/first aid cards, tuberculosis test results, orientation checklists, or pet records.

3. Review any documentation received and call the administrator to discuss the issues. 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.
  - a. On-site follow up must be conducted if documentation was not received or does not adequately support the conclusion that correction has been achieved.
4. Document pertinent details of the call and if the deficiency (ies) have been corrected on [Attachment P: Follow-Up \(DSHS 10-683\)](#).
5. Store the documents sent by the ESF to demonstrate compliance in the Shared Drive.

### Upon completion of all follow up visits:

1. Record corrected and new or uncorrected deficiencies in STARS.
2. Follow SOD writing processes in [Chapter 18: Across All Settings](#) for any new or uncorrected deficiencies.
3.  Follow the STARS and [Electronic Working Paper](#) (EWP) processes to document the follow up.

### General:

1. Consult with the FM when additional issues are discovered during a follow-up that may require an intake.

Example: CRU must be notified if the ESF is conducting activities requiring a Medical Test Site Waiver (MTSW) licensure when the provider has not shown proof of MTSW licensure after citation and follow up visit.

2. The facility must develop a written plan of correction (POC) for any violations and send to the department within ten working days from the receipt of the SOD. A POC is still required if the provider requests an IDR.
3. Document all follow ups on [Attachment P](#) or in the follow up visit section of EWP.



### T. Fire Safety Code Deficiencies

#### Purpose

RCS collaborates with the State Fire Marshal’s Office (SFMO) for the purpose of conducting State Fire Safety Code Annual inspections and fire safety related complaint investigations in ESFs as required in [Chapter 212.12 WAC](#). The SFMO does not have statutory authority to impose remedies when licensed ESFs have disapproved inspections and deficiencies or do not correct fire safety code deficiencies in the specified time frame. RCS as a regulatory agency has the authority to impose citations and enforcement remedies to promote the safety of the residents residing in the facilities and ensure facilities return to substantial compliance.

#### Procedure

##### SFMO Annual Inspections

The SFMO will:

1. Conduct annual fire safety code inspections through an automated SFMO system and conduct complaint investigations when referred by the Complaint Resolution Unit (CRU).
2. Provide the facility with the SFMO detailed report including deficiency(ies), which gives the facility a timeline (generally 30 days) to correct deficiency(ies).
3. Send completed SFMO report(s) to the RCS Field Managers (FMs) and Public Disclosure Unit (PDU) on a weekly basis.

Note: This comes in an email from SFMO titled “heads up.”

The FM will:

1. Review the SFMO reports within five working days of receipt.
2. Ensure the licensors/complaint investigators have access to review SFMO reports to establish history of uncorrected fire safety code deficiency(ies) in preparing for full licensing inspections or complaint investigations.
3. Assign a complaint investigator to complete the RCS portion of an SFMO complaint referral, if needed.
4. Save the SFMO reports electronically in the shared drive following defined naming conventions.

The Licensor/Complaint Investigator will:

1. Conduct the inspection or investigation and review any concerns identified during the [Pre-Inspection Preparation & Activities](#).
2. Consult with the SFMO as needed.
3. Draft SOD report using [WAC 388-107-0700 \(3\)](#) including details the SFMO identified as meeting serious fire safety code deficiency(ies) when applicable and any observations validating deficiencies.
4. Consult with FM if additional concerns are identified.

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The ESF Compliance Specialist (CS) will:

1. Review the SFMO reports.

### SFMO Annual inspections, re-inspections, or complaints with serious fire safety code issues

The SFMO is responsible for identifying when concerns meet a serious fire safety code deficiency threshold. Below is the procedure to follow if a potentially serious fire safety code deficiency(ies) is(are) identified during an annual licensing re-inspection.

The FM will:

1. Notify the CS when the SFMO has determined a potential deficiency(ies) may be serious or if consultation with the SFMO is needed to determine the potential seriousness of identified fire safety code deficiency(ies).
2. Provide the draft SOD to the CS with the details of the issue(s) identified, including any necessary facility history (i.e., facility census, past SFMO enforcement, etc.).

Note: While the FM may consult directly with the SFMO, it is important to ensure the CS is aware of any potentially serious concerns related to any entity regulated by RCS.

The CS will:

1. Contact the SFMO when requested by the FM to request a determination of the seriousness of an identified potential fire safety code deficiency.
  - a. If fire safety code **does** meet the criteria of needing immediate action by SFMO or RCS, the CS will determine, in collaboration with the SFMO and FM, the best enforcement remedy(ies) for the situation.
    - 1) If the remedy imposed will include a fire watch protocol, the SFMO will provide the specific language to the CS and FM (including how frequent, who is responsible, how long, and reporting requirements).
  - b. If potential fire safety code deficiency **does not** meet criteria for a need for immediate action by SFMO or RCS, then the CS will notify the FM of the SFMO's determination.
2. Send email request for enforcement notice to the Compliance Administrative Assistant 3 (AA3), when remedy(ies) will be imposed.
3. Follow the STARS enforcement referral process if needed.

When enforcement remedies will be imposed, the FM will:

1. Provide any enforcement remedy information to the licensor to verbally impose while on-site if ESF licensors **are** in the process of completing a full licensing inspection at the time.
2. Send a referral to the CRU to generate a 2-Day complaint for RCS investigation if ESF licensors **are not** completing a full inspection at the time.
  - a. Assign a licensor or complaint investigator to go on-site to validate the identified fire safety code deficiency(ies).

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- b. Provide enforcement remedy information to the licensor or complaint investigator to verbally impose while on-site.
3. Follow STARS enforcement referral process.

Compliance AA3 will:

1. Review the email request for enforcement notice.
2. Follow the STARS enforcement referral process.
3. E-Fax or email the completed enforcement notice to the facility either as a pending notification or as a final notice with the RCS Statement of Deficiency (SOD).

#### Facility Compliance

The FM will:

1. Notify the SFMO when, to the best of their knowledge, the facility is likely back in compliance.

The SFMO will:

1. Conduct fire safety code follow-up visit per their agency process, including any needed notifications.

#### SFMO Follow-up Visits (2<sup>nd</sup> and 3<sup>rd</sup> visits) with uncorrected deficiency(ies)

The SFMO will:

1. Conduct fire safety code follow-up visits per SFMO process.
2. Provide the facility with the SFMO detailed report to include any uncorrected deficiency(ies) which gives the facility a timeline (generally 30 days) to correct deficiency(ies).
3. Send completed SFMO report(s) to the RCS FMs and Public Disclosure Unit on a weekly basis.

The FM will:

1. Review the SFMO failed re-visit report within 5 working days.
2. Initiate a 10-day intake with CRU unless prioritized differently by the SFMO.
3. Ensure the licensors/compliant investigators have access to review SFMO reports to establish history of fire safety code deficiency(ies) in preparing for a complaint investigation.
4. Assign a complaint investigator to validate the uncorrected fire safety code deficiency(ies).
5. Provide the draft SOD citing [WAC 388-107-0700 \(3\)](#) to the CS for review with the SFMO, including correction timelines.

The CS will:

1. Provide the draft SOD for the failed follow-up to the SFMO and work in collaboration with the SFMO and the FM to determine the best enforcement remedy(ies) for the situation.
2. Send an email request for enforcement notice to Compliance AA3.
3. Follow the STARS enforcement referral process.

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## Continued Facility Non-Compliance

The SFMO will:

1. If two follow-up visits have been completed by the SFMO and the facility remains non-compliant, provide an email titled “NONCOMPLIANCE” to the Public Disclosure Unit, FM, and CS with the details of the continued deficient practice.

The FM will:

1. Review the SFMO “NONCOMPLIANCE” report within five working days.
2. Ensure the licensors/complaint investigators have access to review SFMO reports to establish history of uncorrected fire safety code deficiency(ies) in preparing for a follow-up visit.
3. Assign a licensor/complaint investigator to complete the follow-up visit to validate the SFMO uncorrected deficiency(ies).
4. Provide the draft SOD citing [WAC 388-107-0700 \(3\)](#) to the CS for review with the SFMO, including correction timelines.
5. Follow the STARS enforcement referral process.
6. Coordinate subsequent visits with the SFMO, if necessary.

The CS will:

1. Review the SFMO “NONCOMPLIANCE” report.
2. Determine, in collaboration with the SFMO and FM, the best enforcement remedy(ies) for the situation and the severity of the deficiency.
3. Send email request for enforcement notice to the Compliance AA3, when remedy(ies) will be imposed.
4. Follow the STARS enforcement referral process.

Compliance AA3 will:

1. Review the email request for enforcement notice.
2. Follow the STARS enforcement referral process.
3. E-Fax or email the completed enforcement notice to the facility either as a pending notification or as a final notice with the RCS SOD.



### U. 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 field. A CHOW of an entity can occur for many reasons, such as:

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

#### Procedure

##### 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 BAAU Checklist.
  - b. Move the electronic file folder into the 'Uploaded ESF' 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 with a cc (carbon copy) to ESF Program Manager.
    - 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, exemption(s);
    - 3) Enforcement history; and
    - 4) Any other information 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.

    - a. Document recommendation in STARS and forward to BOAU.
3. The Business Operations and Analysis Unit (BOAU) will:
  - a. Document applicable notes in the comments in STARS under Application Details.
  - b. Approve and issue the license in STARS.
  - c. Notify BAAU of the approval.

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### 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. Notify BAAU ESF Notification Group of the license issuance via email.
4. Notify the State Fire Marshal, Department of Health/Construction Review Services and Ombudsman via email.
5. Mail a copy of the license letter (generated from STARS), 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.
6. Upload the sent emails, license, and the BAAU Checklist to the RMT.

### Application Void, Cancel, Deny or Withdraw

1. The department will void an application if the applicant does not return information to the department within sixty (60) calendar days of the department's first request for additional information for an incomplete application.
2. The department will cancel an application if the current facility is closed for any reason during the application process. The applicant is notified via email that they must submit an initial license application if they choose to continue the process.
3. The department may deny an application based on [WAC 388-107-1422](#).
4. Applicants may voluntarily withdraw their application at any time by submitting written request to the department.

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## V. Monitoring Visits – Under Construction



## Part II: Appendices

### A. Resources

1. Additional Guidance: Abuse Prevention Review
  - a. Observations for indicators of possible abuse:
    - Client-to-client interaction for possible unsafe behavior of one client toward another.
    - Staff-to-client interactions should support client rights and dignity. Look for staff's demeanor toward clients noting any intimidation, fear, ignoring client's needs, yelling, physical aggression, or verbal abuse.
    - Potential abuse issues including the presence and use of physical or chemical restraints. This may include beds pushed up against the wall, recliners, merry walkers, locks preventing exit. If restraints are present, double check that any restraints used are included in the PBSP and follow [WAC 388-107-0420](#).
    - Uncommon or numerous skin tears.
    - Bruising with injuries with unknown cause.
  - b. [Key Triggers](#)
2. Additional Resources: Interpreter Services
  - a. [Interpreter Slide Deck \(Dec 2024 Support Call\)](#)
  - b. [Language Access SharePoint](#)
  - c. [Long Term Care Manual Chapter 15b](#)
  - d. Spoken language interpreter services covered by the Collective Bargaining Agreement:
    - [Four Corners Translation LLC](#) is our current vendor for in-person interpreters and pre-scheduled phone and video interpreter services.
    - [Universal Language Services](#) provides interpreter services to Medicaid eligible clients.
  - e. For unscheduled/on-demand over the phone or video remote interpreter services:
    - [Four Corners Translation LLC](#)
    - [911 Interpreters](#) (non-Collective Bargaining Agreement vendor; for use in urgent situations)
    - [Language Link](#) (non-Collective Bargaining Agreement vendor; for use in urgent situations)
  - f. To access the contract and schedule an interpreter, send licensors name, email address, and role (User or Requestor Administrator) to [dshsaltsalep@dshs.wa.gov](mailto:dshsaltsalep@dshs.wa.gov).
3. Additional Guidance: Administrative Interview Optional Questions
  - Is there currently an infectious disease outbreak at the facility?
  - Are there any safety issues to be aware of when interacting with the residents?
  - Are any residents out of the facility for an extended period?
  - What do you do if you discover resident rights being violated?
  - How do you handle resident complaints?
  - How do you ensure you are available to speak with residents?
  - Describe your policy for training staff to provide care and services?
  - What time are your meals and snacks?

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- How do you ensure staff are promoting resident choice?
- What is your policy if abuse, neglect, or exploitation is discovered?
- Have you had any incidents in the last 30 days?
- What do you do if a resident is missing?
- What resources do you use with residents who experience challenging behaviors?
- How do you ensure resident safety related to challenging behaviors?
- What is your policy and process for accident or injury? Who do you notify?
- How do staff contact you?
- How do you ensure staffing levels meet resident needs?
- Do you keep a record of staff grievances?
- How do staff access facility policies?
- What are your policies and procedures for emergencies?
- What is your policy for evacuation?
- Which residents have pets (if applicable)?
- Do you have any pets or service animals in the facility?

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### B. Forms

1. [Attachment A: Pre-Inspection Preparation \(DSHS 15-571\)](#)
2. [Attachment B: Request for Documentation \(DSHS 15-572\)](#)
3. [Attachment C: Resident List \(DSHS 15-573\)](#)
4. [Attachment D: Resident Characteristic Roster and Sample Selection \(DSHS 15-574\)](#)
5. [Attachment E: Resident Interview \(DSHS 15-575\)](#)
6. [Attachment F: Other Contact Interview \(DSHS 15-576\)](#)
7. [Attachment G: Environmental Observations \(DSHS 15-577\)](#)
8. [Attachment H: Resident Record Review \(DSHS 15-578\)](#)
9. [Attachment I: Staff and Administrative Record Review \(DSHS 15-579\)](#)
10. [Attachment J: Staff Interview \(DSHS 10-703\)](#)
11. [Attachment K: Notes/Worksheets \(DSHS 15-581\)](#)
12. [Attachment L: Exit Preparation Worksheet \(DSHS 15-582\)](#)
13. [Attachment M: Food Service Observations and Interviews \(DSHS 15-583\)](#)
14. [Attachment N: Medication Pass Worksheet \(DSHS 15-584\)](#)
15. [Attachment O: Staff Schedule Worksheet \(DSHS 15-585\)](#)
16. [Attachment 02: Staff Schedule Worksheet – 8 Hour Shift \(DSHS 15-585A\)](#)
17. [Attachment 03: Staff Schedule Worksheet – 12 Hour Shift \(DSHS 15-585B\)](#)
18. [Attachment P: Follow-Up \(DSHS 10-683\)](#)
19. [Attachment Q: Medication Observations Form \(DSHS 15-603\)](#)
20. [Infection Prevention and Control \(IPC\) Inspection Tool \(DSHS 13-939\)](#)
21. [RCS IPC Assessment Notes \(DSHS 13-944\)](#)
22. [Character, Competency & Stability \(CCS\) Determination \(DSHS 03-506\)](#)
23. [ESF Confidential Identifier List \(DSHS 27-238\)](#)



## C. Glossary of Terms

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**Abandonment** – as defined in [RCW 74.34.020](#).

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**Abuse** – as defined in [RCW 74.34.020](#).

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**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.

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

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**Agency** – State agency.

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**Background check** – means a name and date of birth check or a fingerprint-based background check, or both. [WAC 388-113-0010](#).

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**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](#).

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

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

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

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**Complaint** – A report communicated to Residential Care Services' (RCS) Complaint Resolution Unit (CRU) by anyone NOT acting as an administrator or designee for a provider licensed or certified by RCS. The report alleges abuse, neglect, exploitation, or misappropriation of property for one or more vulnerable adult. The complainant could be a vulnerable adult, a family member, a health care provider, a concerned citizen, other public agencies, or a mandated or permissive reporter. Report sources may be verbal or written.

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**Complaint investigation** – means an onsite investigation as a result of receiving a complaint related to provider practice.

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**Complaint investigator (CI)** – means an RCS regulatory staff assigned to investigate a complaint received by the department.

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**Comprehensive interview, record review or observation** – Involves pre-determined subject areas that licensors are required to look at during every inspection for selected individuals. It is in contrast to a focused interview, record review or observation that is in response to an identified issue or concern. Focused reviews are different for every inspection depending on the issues identified.

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**Confidential 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 \(POD\)](#).

**Confidential information** – A type of information that is protected by state or federal laws, including information about vulnerable adults, DSHS clients, employees, vendors or contractors, and agency systems unavailable to the public without legal authority.

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

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

**Corrected deficiency [community programs]** – means the department has cited a violation of WAC or RCW following an inspection or complaint investigation and the violation was found to be corrected at the time of a subsequent inspection for the purpose of verifying whether such violation has been corrected.

Note: One or more deficiencies may be corrected while others remain uncorrected.

**Cover letter** – A cover letter is the document used in Community Programs to communicate the determination of noncompliance with the regulatory requirements to the entity. The cover letter is an official, legal record that is available to the public on request.

**Date of Hire** – The first day the long-term care worker or staff is employed by the employer.

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

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

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

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

**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.

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**Enhanced Services Facilities (ESF)** – means a facility that provides support and services to persons for whom acute inpatient treatment is not medically necessary. [RCW 70.97.010](#).

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**Entity** – A standard term used throughout this document to depict the long-term care program homes, facilities, and licensees participating in transforming lives of the vulnerable adults living in residential settings.

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**Entrance date** – means the first date RCS staff is on site.

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**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.

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**Exemption or 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.

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**Exit date** – means the last date RCS staff is on site.

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**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.

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**Facility** – as defined in [RCW 74.34.020](#).

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

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**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.”

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**Financial exploitation** – as defined in [RCW 74.34.020](#).

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**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.

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**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.

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**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.

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**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.

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

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**Great bodily harm/injury** – means bodily injury which creates a high probability of death, or which causes serious permanent disfigurement, or which causes a permanent or protracted loss or impairment of the function of any bodily part or organ.

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**Health care** – The care, services or supplies related to the health of a vulnerable adult, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling for a physical or mental condition, a prescribed drug, device, or equipment.

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**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.

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**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.

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**Improper use of restraint** – as defined in [RCW 74.34.020](#).

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

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**Initial inspection** – A generic term use to describe a process conducted by RCS staff in evaluating a prospective licensee for compliance with the statutes and regulations required for an Adult Family Home license, an Assisted Living Facility license, or an Enhanced Services Facility license.

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**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.

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**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.

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**Last Date of Data Collection (LDDC)** – The last date information was collected for the Compliance Determination (CD).

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**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.

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**License Fee** [also referred to as Bed Fee] – means the annual fee established in the [Omnibus Appropriations Act](#) which cover the department’s annual licensing and oversight activity costs and must include the department’s cost of paying providers for the amount of the license fee attributed to Medicaid clients.

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**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.

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**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](#).

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**Mechanical restraint** – as defined in [RCW 74.34.020](#).

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**Medically fragile** – means a chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled nursing interventions. If these medically necessary interventions are interrupted or denied, the resident may experience irreversible damage or death. Examples of specialized medical care and treatment for medically fragile residents include but are not limited to: IV therapies requiring monitoring of vital signs and dose titration dependent on lab values; wound care requiring external vacuum or other mechanical devices for debridement; complicated wound care requiring other specialized or extensive interventions and treatment; ventilator or other respiratory device dependence and monitoring; dependence on licensed staff for complex respiratory support; and peritoneal or hemodialysis (on-site).

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

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**Mental abuse** – as defined in [RCW 74.34.020](#).

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**Mental disorder** – means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

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**Mental health professional (MHP)** – any person qualified and licensed to provide assessments, diagnosis, and therapy for mental health conditions.

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

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

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**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.

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**Neglect** – as defined in [RCW 74.34.020](#).

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**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.

**Permissive reporter** – means any person, including but not limited to, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults. Permissive reporters are able to report allegations of abandonment, abuse, financial exploitation, neglect, or self-neglect of a vulnerable adult or child to the department but are not legally mandated to report.

**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 (POC)** – means an entity’s written response to cited deficiencies that explains how it will correct the deficiencies and how it will prevent their reoccurrence.

**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.

**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).

**Referral** – when a report includes other jurisdictions outside of RCS, including but not limited to Adult Protective Services (APS), Department of Children, Youth and Families (DCYF), Department of Health (DOH), Department of Licensing (DOL), Medicaid Fraud Control Division (MFCD), or Law Enforcement (LE). Send the intake to the other agency as a referral.

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

**Regulatory staff/Regulator** – RCS staff responsible for enforcing the rights, safety, and health regulations of individuals living in Washington’s licensed or certified residential settings.

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

- **Public** – are generally residents or clients, family of residents or clients, Long Term Care Ombudsman staff, facility staff when it is clear they are not making an official facility report or are reporting as whistle blowers, hospital staff, and teachers.

## CHAPTER 15: Enhanced Services Facilities (ESF)



- **Facility** – are generally facility or agency Administrators or other management staff making a report as the official “facility” or provider report, staff who leave the facility/agency phone number and give permission to call them back, staff who state they reported their call to the hotline to their management.
- **State Employees** – are generally DSHS staff who are making a report in the natural course of their job duties.

**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.

**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](#).

**Significant change [ESF]** – as defined in [WAC 388-107-0001](#).

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

**Statement of deficiencies (SOD)** – The official, publicly-disclosable, written report document from RCS staff that identifies violations of statute(s) and/or regulation(s), failed facility practice(s) and relevant findings found during a complaint/incident investigation conducted at an any setting regulated by RCS. Included in SODs for AFHs and ALFs 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.

**Substantial bodily harm/injury** – means:

- A substantial impairment of a person's physical condition requiring professional medical treatment.
- Loss of consciousness, concussion, bone fracture, muscle tears, disfiguring lacerations, or wounds requiring multiple sutures.
- Injury requiring corrective or cosmetic surgery.

## CHAPTER 15: Enhanced Services Facilities (ESF)



- Substantial bodily injury involves temporary but substantial disfigurement or loss/impairment of bodily function.
- Injury that creates a substantial risk of death, serious permanent disfigurement, or prolonged loss/impairment of body function.

**Uncorrected deficiency [community programs]** – means the department has cited a violation of WAC or RCW following an inspection or complaint investigation and the violation remains uncorrected at the time of a subsequent inspection for the specific purpose of verifying whether such violation has been corrected.

Note: One or more deficiencies may be corrected while others remain uncorrected.

**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](#).

**Waiver** – means a temporary situation granted by CMS which waives an entity's requirement to comply with a specific regulatory requirement.

**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.

**Whistle blower** – means a resident, employee of an entity, or any person licensed under [Title 18 RCW](#), who in good faith reports alleged abandonment, abuse, financial exploitation, or neglect to the department, the department of health or to a law enforcement 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.

## CHAPTER 15: Enhanced Services Facilities (ESF)



### D. Acronym List

AA	Administrative Assistant
ALTSA	Aging and Long-Term Support Administration (now HCLA)
APS	Adult Protective Services
CC	Carbon Copy (in emails)
CCS	Character, Competency and Suitability
CD	Compliance Determination
CDC	Centers for Disease Control and Prevention
CHOW	Change in Ownership
CLIA	Certified Laboratory Improvement Amendment
CPR	Cardiopulmonary Resuscitation
CRS	Construction Review Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DDA	Developmental Disabilities Administration
DOH	Department of Health
DSHS	Department of Social and Health Services
ESF	Enhanced Services Facilities
ESH	Eastern State Hospital
FBI	Foodborne Illness
FDA	Food and Drug Administration
FM	Field Manager
FSA	Field Services Administrator
HCLA	Home and Community Living Administration (previously ALTSA)
HCS	Home and Community Services
ID	Identification
IDR	Informal Dispute Resolution
IPC	Infection Prevention and Control
LDDC	Last Date of Data Collection
LE	Law Enforcement
LTCOP	Long-Term Care Ombuds Program
MHP	Mental Health Professional
PCSP	Person-Centered Service Plan
POC	Plan of Correction
PPE	Personal Protective Equipment
QI	Quality Improvement
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RMT	Record Management Tool

# CHAPTER 15: Enhanced Services Facilities (ESF)



RN	Registered Nurse
SFM	State Fire Marshal
SFMO	State Fire Marshal's Office
SOD	Statement of Deficiency
SOP	Standard Operating Procedures
STARS	Secure Tracking and Reporting System
WAC	Washington Administrative Code
WD	Working Day
WSH	Western State Hospital
WSP	Washington State Patrol

# CHAPTER 15: Enhanced Services Facilities (ESF)



## E. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
05/05/2025	Entire Chapter	Housekeeping updates to chapter, Formatting updates	Comply with the new DSHS branding.	<a href="#">MB R25-047</a> Unit in-services completed with FM and licensors
05/05/2025	Part I.S. Follow-up Visits	Section Added	Provide guidance to staff	<a href="#">MB R25-047</a> Unit in-services completed with FM and licensors
05/05/2025	Part I.T. Fire Safety Code Deficiencies	Section Added	Provide guidance to staff	<a href="#">MB R25-047</a> Unit in-services completed with FM and licensors
05/05/2025	Part I.U. Change of Ownership	Section Added	Provide guidance to staff	<a href="#">MB R25-047</a> Unit in-services completed with FM and licensors
10/01/2023	Entire Chapter	Chapter establishment	Finalization of SOP draft	MB <a href="#">R23-078</a> Training provided through 9/5/2023 Support Call

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