Overview

Residential Care Services (RCS) is responsible for the licensing, certification, and oversight of 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. This chapter contains standard procedures applicable to facilities under RCS' licensing, certification, and oversight. The content is relevant to RCS staff as well as anyone seeking to understand the procedures within this chapter.

For the purposes of this chapter:

- **'Entity'** in this document will refer to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH).
- **'Resident'** will refer to both residents (all settings except CCRSS and ICF/IID) and clients (CCRSS and ICF/IID settings).
- **'Regulator'** will refer to all RCS staff, including contractors, who complete complaint investigations, licensing inspections, surveys, and certification evaluations.

Authority:

- Chapter 70.128 RCW Adult Family Homes (AFH)
- Chapter 18.20 RCW Assisted Living Facilities (ALF)
- Chapter 71A.12 RCW: State Services (CCRSS)
- Chapter 70.97 RCW Enhanced Services Facilities (ESF)
- Chapter 18.51 RCW Nursing Homes (NH)
- Chapter 388-76 WAC Adult Family Homes (AFH)
- Chapter 388-78A WAC Assisted Living Facilities (ALF)
- Chapter 388-101 WAC Certified Community Residential Services and Supports (CCRSS)
- Chapter 388-107 WAC Enhanced Services Facilities (ESF)
- Chapter 388-97 WAC Nursing Homes (NH)
- Chapter 388-101D WAC: Requirements for Providers of Residential Services and Supports
- 42 Chapter 483.400-480 Intermediate Care Facilities for Individuals with intellectual disabilities (ICF/IID)

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

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Part I: Statements of Deficiency (SOD) and Plans of Correction (POC)

A. Data Entry Timelines

Purpose

Inspections, certifications, investigations, and survey activities assigned to Residential Care Services (RCS) staff are tracked by using data entered into the Secure Tracking and Reporting System (STARS) and/or the Automated Survey Processing Environment System (ASPEN). Each tracking system has a unique set of data requirements. RCS must meet the deadlines for entering data into the systems to meet state and federal performance measures. Responsibility for timely data entry is a shared responsibility for field, administrative, and headquarters staff.

Procedure

1. Enter data into the appropriate system at the conclusion of each step. Do not wait until the end of the process.
2. Enter the required data on the first day back upon return from any extended time away from their workstation.
   a. Notify the Field Manager (FM) if unable to enter the data on the first day back to their workstation to remedy the situation.
3. Enter data into the tracking system(s) within 15 working days (WD) of:
   a. The initiation of the first onsite visit
   a. The last onsite visit
   b. The last date of data collection
4. Notify the FM if unable to enter the data within 15 WD.
5. For federal programs (**ICF/IID**, **NH**), follow Centers for Medicare and Medicaid Services (CMS) data entry timelines if applicable unless RCS data entry timelines are more stringent.

Note: ASPEN requires that all intakes *completed* on the same day be included in a single shell. This means the ASPEN Shell start date will match the date of the earliest start date for the intakes included in the Shell. Below is a demonstration of what this may look like:

Intake #1234 – start date 01/03/2024, CD ID 123
Intake #2341 – Start date 01/10/2024, CD ID 234
Exit date for both – 01/24/2024, Shell XXLM11

Intake #	CD ID / Shell ID	Start	Exit/Last Date of Data Collection
1234	123	01/03/2024	01/24/2024
2341	234	01/10/2024	01/24/2024
Both included	XXLM11	01/03/2024	01/24/2024

STARS

(see below for guidance for NH/ICF-IID)

Start Date	• 1st date on site • Coincides with entrance conference • Preparation activities may occur prior to start date
Exit Date	• Last date on site • Coincides with exit (status update) conference • Must never occur *after* last date of data collection
Last Date of Data Collection (LDDC)	• Last date information collected for the Compliance Determination (CD) • Must never occur *prior* to exit date • Coincides with Outcome conference (may occur at exit) • Should occur within 7 calendar days of exit

ASPEN

(must match STARS)

Start Date	• 1st date on site of the earliest intake linked to the ASPEN Shell (see example previous page) • Coincides with entrance conference • Preparation activities may occur prior to start date
Exit Date	• Last date on site • Coincides with exit (outcome) conference • Must never occur after last date of data collection
Last Date of Data Collection (LDDC)	• Is the last date onsite (same as exit date) • Administrators are given up to two working days after exit to submit additional information. • The LDDC *does not* change, even if information is received after that date.

Field Manager Responsibility

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

B. Statement of Deficiency (SOD) – Community Programs

Purpose

The purpose of the Statement of Deficiency (SOD) is to provide documentation in support of a determination of noncompliance with regulatory requirements, and, if necessary, defend the determination. A clear and comprehensive SOD is necessary to provide the entity with the information needed to analyze the problems, identify appropriate corrective action(s), and come into compliance with the regulatory requirements.

A SOD requires the entity to submit a Plan of Correction (POC) to the department, which is then implemented by the entity to achieve compliance with the regulatory requirements.

For the purposes of this section:

- **'Entity'** in this document will refer to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH).
- **'Resident'** will refer to both residents (all settings except CCRSS and ICF/IID) and clients (CCRSS and ICF/IID settings).
- **'Regulator'** will refer to all RCS staff, including contractors, who complete complaint investigations, licensing inspections, surveys, and certification evaluations.

Procedure

1. The regulator will determine if the entity is compliant or noncompliant following the completion of an inspection, certification evaluation, or complaint investigation.
2. If the regulator has determined that the entity is noncompliant with the licensing laws, rules, or regulations they will enter this information accordingly in STARS.
   a. The SOD must be issued within 10 WD from the last date of data collection (LDDC).

   Example: if the LDDC is 08/14/2023, then day one of the 10-working day countdown is 8/15/2023 (or the next working day).

3. The regulator will follow the Principles of Documentation (POD) when writing the SOD. Each citation should include the regulatory reference, a Deficient Practice Statement (DPS), and all relevant findings related to the entity's noncompliance.
4. If enforcement ***is not*** recommended, when the regulator has completed the SOD, the FM will review the SOD (use of the Deficiency Citation Analysis Tool (DCAT) may assist in completing an accurate review). If approved, the FM will electronically sign and date the SOD.
   a. The field may amend SODs and notice letters when there is no enforcement remedy and new information is received relating to evidence in the existing SOD.

5. If enforcement ***is*** recommended:
   a. The referral will be created in the enforcement tab in STARS.
   b. The system generated SOD cover letter must be removed and replaced with the enforcement notice.
   c. The Compliance Specialist (CS) ***must*** approve all SOD amendment(s) if there has been an enforcement remedy imposed.
   d. If an enforcement remedy has been imposed, and the regulator discovers new information through a subsequent/additional investigation not related to the evidence in the existing SOD, a new SOD must be written.

Off-site Documentation (following the on-site visit):

The regulator will:

1. Complete all data collection, including any needed collateral interviews or further record reviews.
   a. This should be kept to the minimum needed to validate findings without overly extending the time it takes to complete the inspection or investigation.
   b. All contacts must be made within seven calendar days of exit, unless receiving approval from the FM to extend this time frame.
2. Review the pertinent findings and confirm analysis of deficiency citations taking into account any existing or previous enforcement remedy from inspections or investigations that occurred during the previous:
   - 36 months for **AFH**, **ALF**, and **ESF;** or
   - 24 months for **CCRSS**.

   a. Determine if the deficiencies are repeat (**AFH** & **CCRSS**)/recurring (**ALF** & **ESF**) or uncorrected. If so, then add this information to the last sentence in the findings of a deficiency, including which subsections of the regulatory reference are applicable.
   b. Determine if the deficiencies present a serious threat to the health, safety, or welfare of the residents served by the entity.
3. Consult with the FM if an enforcement remedy may be recommended, or if other questions arise.

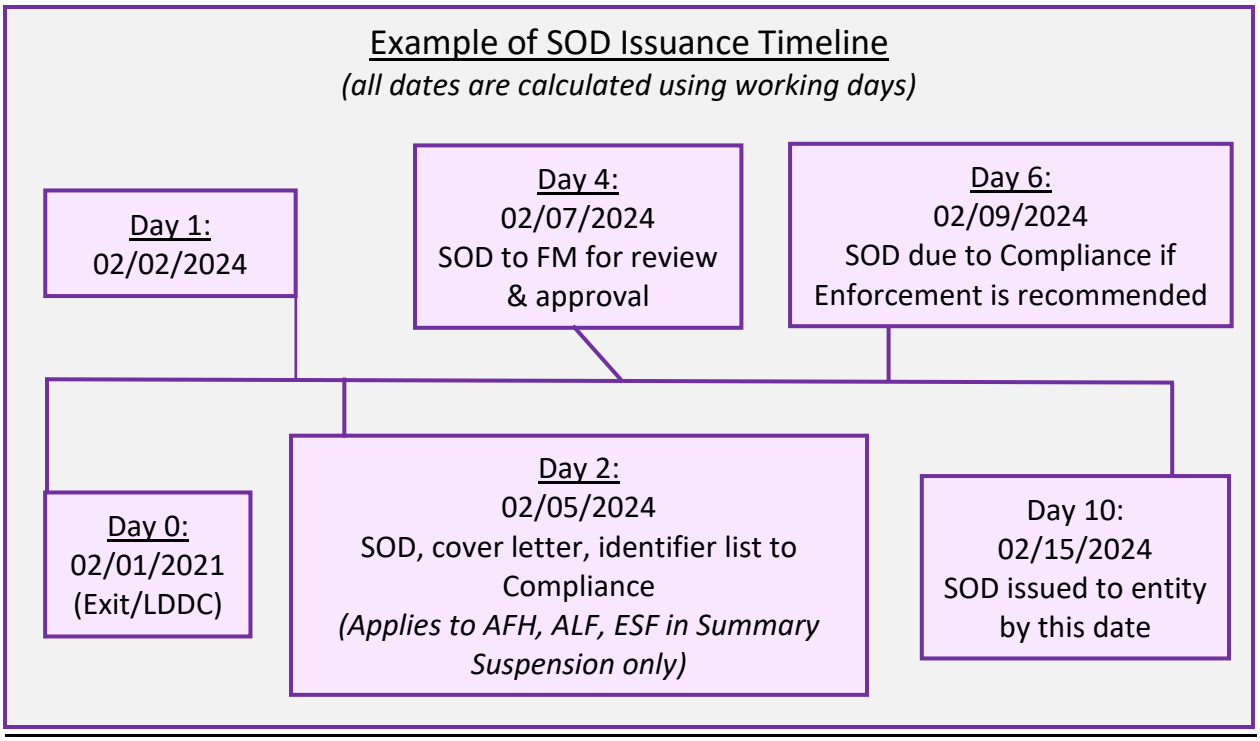
   Note: If an enforcement remedy is recommended, issuing consultations will not be permitted.

4. Complete the following tasks (or divide the tasks among team members if more than one person conducted the inspection or investigation):
   a. Finalize the confidential identifier list(s).
   b. Designate the applicable regulatory statute (i.e., WACs or RCWs) that will be cited in the report.
   c. Document the DPS in relation to cited statutes and regulations following the POD.
5. Enter information into STARS (See STARS Manual for step-by-step instructions).
6. If findings have a direct cause and effect relationship to the deficient practices described in more than one citation, cross-reference those citations following the POD.

7. Identify if the violation is uncorrected or is a *repeat* deficiency for **AFH** & **CCRSS** or *recurring* deficiency for **ALF** & **ESF** (the same statute/regulation, subsection, and issue have been previously cited within the timeframe defined above and are related to an enforcement remedy recommendation).
8. Submit the completed SOD, confidential identifier list (when applicable), and submit to the FM for approval within four WDs of LDDC.
    a. Save the confidential identifier list (as applicable) to the appropriate shared drive for the FM and unit Administrative Assistant 3 (AA3) to receive with the SOD submission.

Review and Approval of SOD

1. If enforcement ***is not*** recommended, the FM/designee will:
    a. Review the completed SOD and cover letter with staff.
    b. Approve and e-sign cover letter and SOD; and
    c. Ensure the SOD report, cover letter, and confidential identifier list are sent to the entity within the timeline defined above.
2. If enforcement ***is*** recommended, the FM/designee will:
    a. Review the completed SOD and cover letter with staff.
    b. Determine which deficiency(ies) is (are) recommended for enforcement remedy and type of remedy recommended.
    c. Create the referral on the Enforcement page within the STARS Compliance Determination (CD) within six WDs of the LDDC.
        1) If immediate enforcement is needed, contact the CS as soon as possible.
    e. Approve and send the e-signed cover letter, SOD, and confidential identifier list to RCSComplianceUnit@dshs.wa.gov.
3. The CS will:
    a. Review the enforcement recommendation to determine if sufficient evidence exists upon which to initiate enforcement remedy, prioritizing workload.
    b. Coordinate the completion, revision, review, and approval of the SOD report with the FM.
4. The Compliance AA3 will:
    a. Follow all steps contained in SOP Chapter 7 – Enforcement for the enforcement remedy to be imposed.



Amendment of SOD

1. The FM/designee will:
   a. Consult with the CS to discuss circumstances when a SOD with a corresponding enforcement remedy may need to be amended. The FM must not amend the SOD until the consultation occurs and the CS approves the amendment.
   b. Upon approval from the CS, amend the SOD.
   c. Review, e-sign and approve the amended SOD; and
   d. If the amended SOD is part of an enforcement remedy, send a new referral in STARS to the CS for review and approval, who will then determine whether it meets enforcement criteria.
2. The CS will:
   a. Review and approve the amending of the SOD and inform the FM of the decision.
   b. Obtain the Compliance and Enforcement Unit Manager/designee's approval and signature for an amended enforcement letter; and
   c. Coordinate delivery of the amended SOD report and amended/continued enforcement letter to the entity.
3. The Compliance AA3 will:
   a. Follow all steps contained in SOP Chapter 7 – Enforcement for the enforcement remedy to be imposed.

> Note: If an IDR results in an amendment to a SOD, refer to Chapter 22 – Informal Dispute Resolution for the process.

C. Statement of Deficiency (SOD) – NH

Purpose

The purpose of the Statement of Deficiency (SOD) is to provide documentation in support of a determination of noncompliance with regulatory requirements, and, if necessary, defend the determination. A clear and comprehensive SOD is necessary to provide the entity with the information needed to analyze the problems, identify appropriate corrective action(s), and come into compliance with the regulatory requirements.

A SOD requires the entity to submit an electronic Plan of Correction (ePOC) to the department, which is then implemented by the entity to achieve compliance with the regulatory requirements.

For the purposes of this section:

- **'Entity'** in this document will refer to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH).
- **'Resident'** will refer to both residents (all settings except CCRSS and ICF/IID) and clients (CCRSS and ICF/IID settings).
- **'Regulator'** will refer to all RCS staff, including contractors, who complete complaint investigations, licensing inspections, surveys, and certification evaluations.

Procedure

1. The regulator will determine if the entity is compliant or noncompliant after a survey or complaint investigation.
2. If the regulator determines that the provider is noncompliant with licensing laws, rules, or regulations they will enter this information accordingly in the Automated Survey Processing Environment System (ASPEN).
   a. The SOD report form (CMS-2567) must be issued within 10 working days (WD) from the exit date.

   Example: if the exit is 08/14/2023, then day 1 of the 10-working day countdown is 8/15/2023 (or the next working day).

3. The regulator will follow the Principles of Documentation (POD) when writing the SOD. Each citation should include the regulatory reference, a Deficient Practice Statement (DPS), and all relevant findings related to the entity's noncompliance.

4. If enforcement ***is not*** recommended, when the regulator has completed the SOD, the Field Manager (FM) will review the SOD (use of the Deficiency Citation Analysis Tool (DCAT) may assist in completing an accurate review). If approved, the FM will electronically sign and date the SOD.
   a. The field may amend SODs and notice (cover) letters when there is no enforcement remedy and new information is received relating to evidence in the existing SOD.
5. Once approved, the SOD is then posted to the ePOC system in ASPEN.
   a. The field will draft the notice (cover) letter using the templates available in ASPEN when the citation scope and severity (S/S) level is A, B, C, D, E, and/or F when there is "Opportunity to Correct."
   b. The field will draft back in compliance (BIC) notice letters using the templates available in ASPEN for all cases when enforcement has **not** been implemented.

> Example: On a full survey, the NH receives a GG letter drafted by the Compliance Specialist (CS) stating that they will be in Denial of Payment within 90 days. The field conducts a revisit and determines the facility was back in compliance prior to the 90-day timeline. The BIC letter is issued by the field even though the original letter was drafted by the CS since the enforcement was **not** implemented.

6. If enforcement ***is*** recommended:
   a. The referral will be created in the enforcement tab in STARS.
   b. The CS will draft the notice (cover) letters when there are citations with "No Opportunity to Correct." This includes:
      1) Citation scope/severity (S/S) at level G, GG, H, I, J, K, and/or L level citations;
      2) Substandard Quality of Care (SQC);
      3) Immediate Jeopardy (IJ);
      4) An additional investigation/survey when the entity is already deemed out of compliance; or
      5) A failed post-survey revisit with citations at S/S level D or higher.
   c. The CS ***must*** approve all SOD amendment(s) if there has been an enforcement remedy imposed.
   d. If an enforcement remedy has been initiated, and the surveyor discovers new information through a subsequent/additional investigation not related to the evidence in the existing SOD, a new SOD must be written.

Off-site Documentation (following the on-site visit):

The regulator will:

1. Complete all data collection, including any needed collateral interviews or further record reviews.
   a. This should be kept to the minimum needed to validate findings without overly extending the time it takes to complete the inspection or investigation.
   b. All contacts must be made within seven calendar days of exit, unless receiving approval from the FM to extend this time frame.

2. Review the pertinent findings and confirm analysis of deficiency citations, taking into account any existing or previous enforcement remedy from inspections or investigations that occurred during the previous 15 months.
3. Consult with the FM if an enforcement remedy may be recommended, or if other questions arise.
4. Complete the following tasks (or divide the tasks among team members if more than one person conducted the survey or investigation):
   a. Finalize the resident sample identifier list(s).
   b. Designate the applicable regulatory statute (i.e., F-tags, CFRs, WACs, or RCWs) that will be cited in the report.
   c. Document the DPS in relation to cited statutes and regulations following the POD.
5. Complete page one of the SOD using the templates provided in the ASPEN/ACO citation manager/content library when entering initial comments (F0000).
6. Document violations that result in little or no negative outcome and minimal potential for harm for residents on the CMS "A" form and incorporate the form into the SOD.
7. If findings have a direct cause and effect relationship to the deficient practices described in more than one citation, cross-reference those citations following the POD.

> Note: Reference should only go one way, from F-tag with the least amount of detail to the F-tag with the most detail regarding the specific issue.

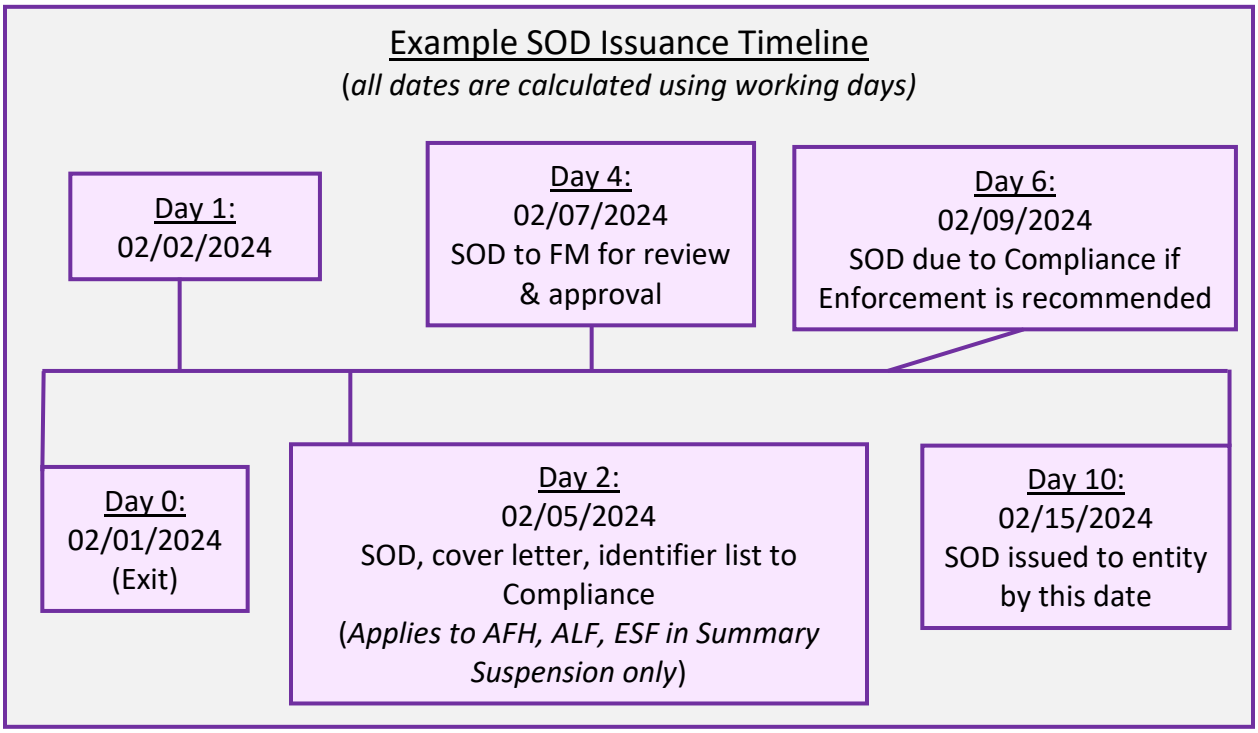
8. Document any corresponding Washington state statutes and regulations on the Nursing Home State Survey report (DSHS 10-207) form and upload to ASPEN. Any WAC citations with no corresponding F-tag will be documented in ASPEN on a separate SOD.
9. If enforcement remedy is being recommended, document all deficiencies cited for that visit and/or the ASPEN event ID on the Licensee History Memo (LHM).
10. Submit the completed SOD, confidential identifier list (when applicable), and submit to the FM for approval within four WDs of exit date. Include the LHM (when applicable).

Review and Approval of SOD

1. If enforcement ***is not*** recommended, the FM/designee will:
   a. Review the completed SOD and cover letter with staff.
   b. Approve and e-sign cover letter and SOD; and
   c. Ensure the SOD report, cover letter, and confidential identifier lists are sent to the entity within 10 WDs of the exit via the ePOC system in ASPEN.
2. If enforcement ***is*** recommended, the FM/designee will:
   a. Review the completed SOD and cover letter with staff.
   b. Determine which deficiency(ies) is (are) recommended for enforcement remedy and type of remedy recommended.

c. Create the referral on the Enforcement page within the STARS CD within six WDs of the exit date.
   1) If immediate enforcement is needed, contact the CS as soon as possible.
d. Approve and send the e-signed cover letter, SOD, and confidential identifier list to RCSComplianceUnit@dshs.wa.gov.

3. The CS will:
   a. Review the Enforcement Recommendation to determine if sufficient evidence exists upon which to initiate enforcement remedy, prioritizing workload.
   b. Coordinate the completion, revision, review, and approval of the SOD report and LHM, if applicable, with the FM.
4. The Compliance AA3 will:
   a. Follow all steps contained in SOP Chapter 7 – Enforcement for the enforcement remedy to be imposed.



Amendment of SOD

1. The FM/designee will:
   a. Consult with the CS to discuss circumstances when a SOD with a corresponding enforcement remedy may need to be amended. The FM must not amend the SOD until the consultation occurs and the CS approves the amendment.
   b. Upon approval from the CS, amend the SOD.
   c. Review, e-sign and approve the amended SOD; and
   d. If the amended SOD is part of a current enforcement remedy, send a new referral in STARS to the CS for review and approval, who will then determine whether the amended SOD meets enforcement criteria.

2. The CS will:
   a. Review and approve the amending of the SOD and inform the FM of the decision.
   b. Obtain the Compliance and Enforcement Unit Manager/designee's approval and signature for an amended enforcement letter; and
   c. Coordinate delivery of the amended SOD report and amended/continued enforcement letter to the entity.
3. The Compliance AA3 will:
   a. Follow all steps contained in SOP Chapter 7 – Enforcement for the enforcement remedy to be imposed.

> Note: If an IDR results in an amendment to a SOD, refer to Chapter 22 – Informal Dispute Resolution for the process.

D. Statement of Deficiency (SOD) – ICF/IID (Under Construction)

E. Licensee History Memo (LHM) – NH Only

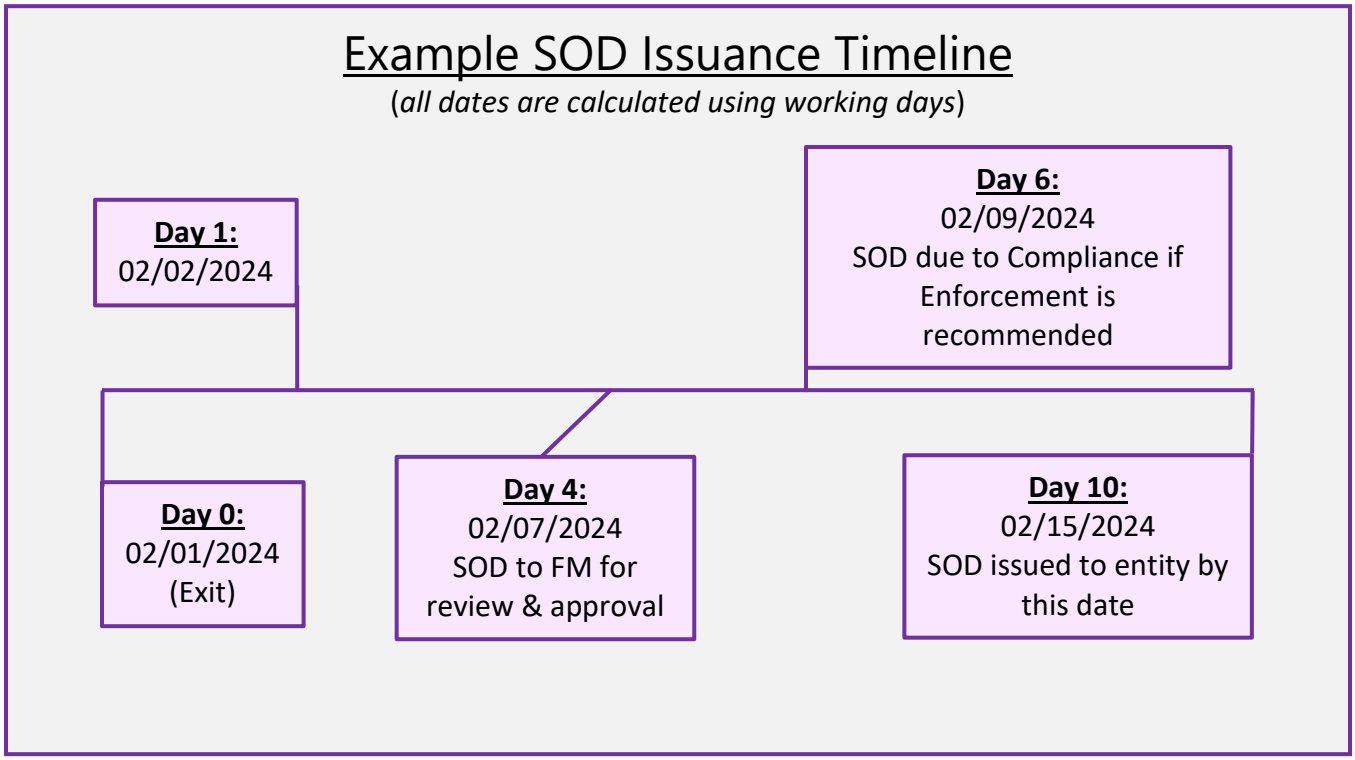
Purpose

Each field office will complete Licensee History Memos (LHMs) for all surveys and complaint investigations resulting in citations at a scope and severity (S/S) level of D and above. This helps to establish a basis upon which enforcement remedies are taken in NHs and allows for consistent documentation of all enforcement remedies.

Procedure

LHM Documentation Process

1. Upon completion of the SOD that includes citations at a S/S level of D and above the Surveyor/CI will:
   a. Complete a LHM in the Aspen Central Office (ACO) system if enforcement remedy is recommended (see the ACO Procedure Guide for more information).
   b. Review the completed SOD with the FM following timelines defined in the 'Statement of Deficiency' section.
2. The FM/designee will:
   a. Review, edit and finalize the SOD and LHM within six WDs of exit date.
3. The CS will:
   a. Review the SOD report and LHM.
   b. Process the enforcement recommendation through STARS.



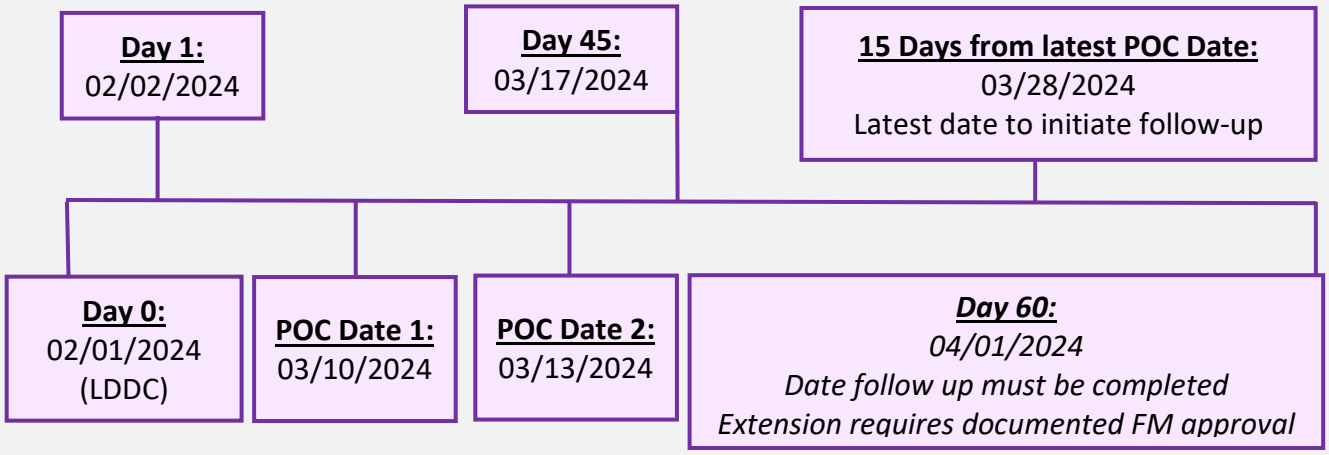
F. Attestation and Plan of Correction (POC) – Community Programs

Purpose

When an entity has received a citation, they must provide RCS with a Plan of Correction (POC) within 10 calendar days of receiving the SOD from RCS (or 10 working days for **ESF**). The POC must include the date each deficiency has been or will be corrected. Correction dates must not exceed 45 calendar days from the last date of data collection (LDDC), unless approved by the FM. The 45-calendar day count begins with the next full day after data collection is complete.

Example

- If the 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 attested 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:



The department may require correction dates that are less than 45 calendar days when there is a threat to resident health/safety or when a condition on a license has been initiated. RCS will review the POC within five WD of receipt and determine if the dates of compliance are acceptable.

AFH, **ALF**, and **ESF** providers also submit an attestation statement for each citation certifying that the entity has or will correct each deficiency.

Note: this does not apply in *Revocations* or *Summary Suspensions*.

All attestation statements are a part of the SOD report for **AFH**, **ALF**, and **ESF** and are retained in the licensing file. The attestation statement must be signed and include the date that the deficiency has been or will be corrected (unless the entity is disputing the deficiency through the Informal Dispute Resolution [IDR] process). The entity should immediately begin initiating corrective action in response to deficiencies cited upon verbal notice of findings during inspections or complaint investigations.

Note: **CCRSS** providers are still required to submit a plan of correction within 10 calendar days, even when requesting an IDR.

If disputing the deficiency through the IDR process, and there are no changes to the SOD upon completion of the dispute, the entity is required to submit the attestation date and letter/documentation to demonstrate correction and that the entity is back in compliance (BIC).

Procedure

Entity Attestation Statement Notification

1. The regulator will:
   a. Inform the entity during the exit conference that a SOD report will be issued within 10 WDs of the LDDC.
   b. Inform the entity during the exit conference that an attestation statement and POC must be completed for each cited deficiency in the SOD and returned to the department within 10 calendar days of receiving the SOD report.
   c. When necessary to protect resident health, safety, or welfare, the regulator may request a written safety plan submitted by the entity before exiting.

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

Review of POC (Attestation Statement and Letter/Documentation)

1. The regulator will:
   a. Review the attestation statement within five WDs of receipt (or request the FM review the attestation if the regulator will not be available).
      1) Confirm that the attestation statement has the provider's signature and date by which each cited deficiency has been or will be corrected.
   b. Enter the correction date(s) in STARS.
   c. Depending on the deficiency, monitor compliance.
   d. Review any letters or documentation received from the entity verifying correction.
   e. Call the provider to discuss the deficiencies to determine if sufficient information or documentation is present to justify reporting the deficiency as corrected or to recommend to the FM an on-site revisit needs to be conducted.
      1) If there is sufficient information or documentation to determine the deficiency can be reported as corrected, document the pertinent details of the telephone conversation (including a statement identifying whether the entity was found back in compliance).

   2) Retain any documents received from the entity in the working papers.
   f. Consult with FM if there are questions or concerns about the attestation statement or letter/documentation received.
2. The Unit AA3 will:
   a. Call the provider or administrator on the 11th day (or next WD if on a weekend or holiday) if the attestation/POC is not received by the 10th calendar day (10th WD for **ESF**). Remind them to submit the documentation to the department by the next working day.

> Note: if the POC due date falls on a weekend or state/federal holiday, and the POC was received outside of business hours by the date due, then the AA call would not be required.

   b. Document the date and time of the call in the electronic tracking tool.
   c. If no attestation statement is received after the first reminder call, consult with the FM.
3. The FM/designee will:
   a. Call or meet with the entity to:
      1) Review the date(s) on the attestation statement if not acceptable; or
      2) Review the department's concerns related to the entity's failure to submit a signed attestation statement with acceptable dates for each cited deficiency in the SOD; and
      3) Obtain a signed attestation statement with acceptable dates for each cited deficiency in the SOD.
   b. Determine if an on-site visit needs to be conducted if no acceptable evidence is received indicating the entity is back in compliance.
   c. Initiate recommendation for enforcement remedy when the entity is unable or unwilling to comply with the POC attestation requirements.

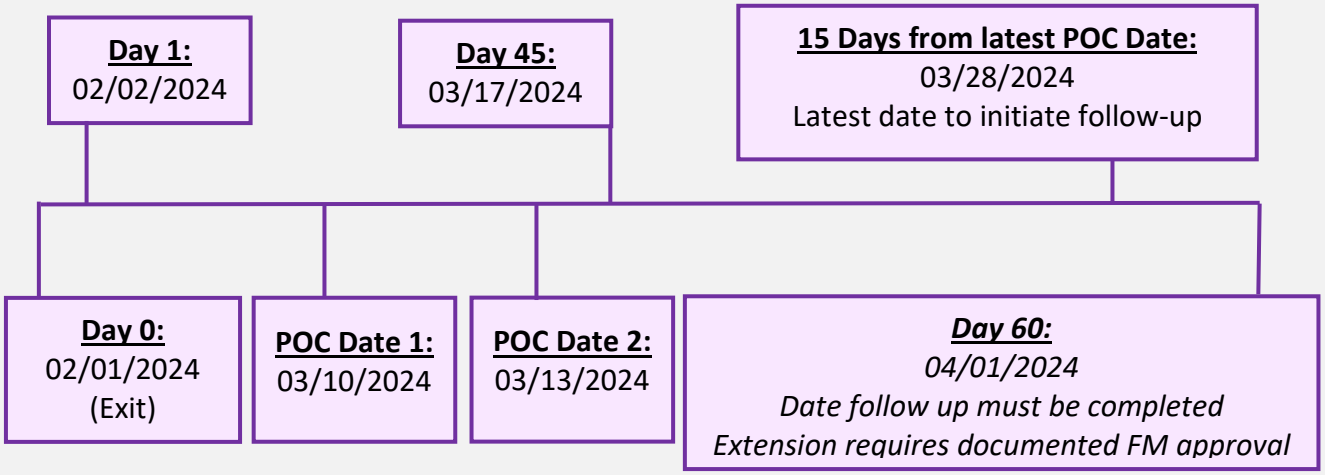
G. Electronic Plan of Correction (ePOC) – NH

Purpose

When an entity has received a citation, they must provide RCS with an ePOC within 10 calendar days of receiving the SOD from RCS. The ePOC must include the date each deficiency has been or will be corrected. Correction dates must not exceed 45 calendar days from the exit date, unless approved by the FM. The 45-calendar day count begins with the next full day after exit.

Example

- If the Exit Date 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 NH has attested the deficient practice will be corrected (POC date). In the example scenario, the NH has two deficiencies with different correction dates. The timeline below demonstrates how this would be mapped out:



The department may require correction dates that are less than 45 calendar days when there is a threat to resident health/safety or when a condition on a license has been initiated. RCS will review the ePOC within five WD of receipt to verify it meets the required elements to correct the identified issue(s). The entity may specify in the ePOC they are not in agreement with the findings contained in the SOD report, but this does not alter the entity's responsibility to submit an acceptable ePOC.

If disputing the deficiency through the IDR process, and there are no changes to the SOD upon completion of the dispute, the entity is required to submit documentation to demonstrate correction and that the entity is back in compliance.

Procedure

ePOC Notification

1. The regulator will:
   a. Inform the entity prior to exit that a SOD report will be issued within 10 WDs of exit date, through the ePOC system.
   b. Inform the entity prior to exit that the POC must be completed for each cited deficiency in the SOD and returned to the department through the ePOC system within 10 calendar days of receiving the SOD report.
   c. When necessary to protect resident health, safety, or welfare, the regulator may request a written safety plan submitted by the entity before exiting.

   Note: This should only be done with FM and/or RA approval.

Review of ePOC

1. The regulator will:
   a. Review the ePOC within five WDs of receipt (or request the FM review if the regulator will not be available). Confirm the ePOC for each deficiency includes:
      1) How the entity will correct the deficiency for each numbered resident.
      2) How the entity will protect residents from similar situations.
      3) Measures the entity will take or the systems it will change to ensure that the problem does not recur.
      4) How the entity plans to monitor its ongoing performance to sustain compliance.
      5) Dates corrective action will be completed; and
      6) Title of person responsible for correction.
   b. If the ePOC ***does*** meet the required elements listed above, notify the FM and Unit AA3 that the ePOC is accepted and save the survey packet to the shared drive.
   c. If the ePOC ***does not*** meet the required elements listed above, review the missing elements with the FM to determine if the FM agrees that the ePOC does not meet the required elements. Document the reason for the rejection in ePOC for each deficiency cited and that the entity was contacted out of courtesy to ensure open communication. This should also be documented on the POC form or the CMS 807 as part of the revisit working papers.

ePOC Not Received

1. If the ePOC is not received by the 10th calendar day (or next WD if the 10th calendar day falls on a weekend or holiday):
   a. the ePOC system will email the administrator and remind them to submit the documentation to the department. The system will continue to send daily reminders to both the entity and the FM until the ePOC is complete.
   b. If the administrator does not respond to the first email reminder within one working day, the unit AA3 will:

1) Call the administrator on the next WD and remind them to submit the ePOC within the next 24 hours.
2) Document the date and time of the call.

c. If the e-POC is still not received by the 15th calendar day following the exit date, the FM/designee will:
   1) Determine if an unannounced on-site revisit needs to be conducted.
   2) Call or meet with the NH to:
      a) Review the department's concerns related to the NH's failure to submit an ePOC that meets the required elements; and
      b) Obtain the ePOC.

d. If the NH is unable or unwilling to comply with ePOC requirements, initiate a recommendation for enforcement remedy through the Enforcement page in STARS.

H. Plan of Correction (POC) – ICF/IID (Under Construction)

I. Confidential Identifier Lists – AFH, ALF, CCRSS, ESF, and ICF/IID

Purpose

Identifiers are used when writing a Statement of Deficiency (SOD) to protect the identity of the individuals named in the document. When the SOD is issued to the entity, a confidential identifier list must be included to assist the entity with identifying where to focus corrective actions.

Procedure

Regulatory Staff will:

1. Document the names of all individuals identified as part of the inspection or investigation process in the working papers.
2. When non-compliance is identified, write a SOD outlining the deficiency(ies) and related evidence following the Principles of Documentation (POD).
3. Assign confidential identifiers to all sampled residents.
4. Assign confidential identifiers to all staff ***named*** in the SOD, following guidance in the POD.
5. Include with the SOD a confidential identifier list using the approved DSHS form. Also include any pet identifiers if the non-compliance is related to pets.
   a. For **Adult Family Homes (AFH)**, Household members (HH) must be included if the citation is related to household members (i.e., deficiencies related to background checks, etc.).
   b. Collateral Contacts (CC) must ***not*** be included in the identifier list unless that information is required for the entity to address the deficiency. Inclusion of the Collateral Contact must be approved by the Field Manager (FM).

   > Note: RCW 74.34.035 addresses confidentiality requirements for reporters. RCW 43.190.090, RCW 74.39A.060 , and WAC 365-18-110 address confidentiality of Ombuds. Ombuds' identities should never be disclosed without their express permission.

   c. If an entity staff requests to remain anonymous, identify them in the SOD as a Collateral Contact (CC) and do not include their information in the identifier list.
      1) Explain to the individual that RCS will keep their information anonymous, except as required by law.

Part II: Principles of Documentation (POD)

For the purposes of this section:

- **'Entity'** in this document will refer to Adult Family Homes (AFH), Assisted Living Facilities (ALF), Certified Community Residential Services and Supports (CCRSS), Enhanced Services Facilities (ESF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and Nursing Homes (NH).
- **'Resident'** will refer to both residents (all settings except CCRSS and ICF/IID) and clients (CCRSS and ICF/IID settings).
- **'Regulator'** will refer to all RCS staff, including contractors, who complete complaint investigations, licensing inspections, surveys, and certification evaluations.

A. Legal Aspects of the Statement of Deficiency (SOD)

Purpose of a Regulatory Visit

The regulatory visit process is designed to ensure the entity providing residential support services to residents is in compliance with its specific statutes and regulations. The regulatory visit, with supporting documentation, becomes an important part of subsequent legal proceedings evolving out of the visit.

The regulatory visit process, along with the documentation records, determines the compliance or noncompliance of providers and suppliers. The regulatory staff provides the facts that justify any resulting enforcement remedy and the record on which to defend that action in the appeals process. The State Agency's or the Federal Government's certification of compliance or noncompliance with the applicable requirements is an official finding and determines whether or not the provider or supplier may participate in the Medicare or Medicaid program.

Legal Processes following a Regulatory Visit

Regulatory staff's documentation of observations, interviews, and record reviews must be objective, consistent, and accurate. Each data source becomes an important part of any legal proceedings subsequent to the regulatory visit, such as reconsiderations, judicial reviews, reviews by the Board's Appellate Division, or hearings before an administrative Law Judge (ALJ) of the Departmental Appeals Board (DAB).

An entity may request a formal reconsideration when the entity determines it does not agree with a cited deficient practice that can affect its ability to qualify for participation in the Medicare/Medicaid program.

In the event an entity is determined to no longer meet the regulatory requirements resulting in termination or alternate remedies/sanctions, the actual termination, projected termination, or remedy may be appealed through an evidentiary hearing before an ALJ. During a hearing, the government has the responsibility to provide facts and evidence to support the decision that the entity should be terminated or be subject to alternate remedies of enforcement. The evidence must provide the underlying reason, basis, or rationale for the findings of noncompliance with the regulatory requirement(s). Such a hearing is an adversarial proceeding; witnesses are called to testify for the entity and for the State or Federal regulations and are subject to cross examination.

Importance of Documentation

The primary evidence is the SOD along with all other documentation used to establish the determination of the regulatory process results, such as working papers, photos, cell phone contents and electronically stored documentation. The ALJ relies on the testimony of witnesses and the documentation from the regulatory process in making a decision. All documentation used at the hearing becomes part of the public record.

In conclusion, the ALJ issues a written decision as to whether or not the entity should be found in compliance with the regulatory requirements of the program. The ALJ is usually not a health professional; therefore, it is important the regulator present the findings in plain language. For this reason, it is important the SOD does not contain medical (technical) jargon or abbreviations a lay person would not readily understand.

If the State Agency or Federal Government or the entity is dissatisfied with an ALJ decision or dismissal, it may file a request for review to the DAB Appellate Division. If the entity is dissatisfied with the outcome of the DAB review, the entity has the right to seek judicial review. The State Agency and Federal Government do not have this right.

The Court's review is limited to the record of the proceedings before the ALJ and the DAB's Appellate Division with the regulatory process documentation continuing to be a crucial aspect of the proceedings.

The SOD documentation remains the vital element in the record to support a determination of noncompliance with regulatory requirements, and, if necessary, to defend the determination before the public, during the appeals process, or in court. The documentation of each and every regulatory process should be treated as if it will be subject to scrutiny. The determination of compliance, as well as noncompliance, must be based on objective and factual observations, record review, and interviews, impulsive and vague conclusions as well as assumptions should be avoided.

If a regulator encounters information or evidence involving resident outcomes during the course of the regulatory process, the regulator should make every effort to associate the cited deficiencies to the effects they can have on residents or the provision of care, services, and treatments to residents. The deficiency citations must also relate to the statutory or regulatory requirements.

In summary…

A clear and comprehensive SOD is necessary to provide the entity with the information needed to analyze the problems, identify appropriate corrective action(s), and come into compliance with the regulatory requirements.

B. Principle 1: Entity Compliance and Noncompliance

When an entity is determined to be in compliance with all statutory or regulatory requirements following the inspection/investigation process, RCS sends a letter containing the explicit statement, "There were no deficiencies found."

When an entity is determined to ***not*** be in compliance with any statutory or regulatory requirements following the inspection/investigation process, a Statement of Deficiency (SOD) with a cover letter is sent to the entity. The SOD must detail the noncompliance identified, including areas that are sent as consultations, if applicable.

Note: For **NH**, the F0000 page must include a sentence detailing which complaint intakes, if any, were investigated as part of the annual survey process. Templates are provided in the citation manager/content library in ASPEN/ACO.

NH Example: The following complaints were investigated as part of the survey:
<<List the complaints IDs. If no deficiencies found, this must be explicitly written.>>

C. Principle 2: Plain Talk

Using a 'plain talk' approach when developing a SOD ensures the deficiency citation is written clearly, objectively, and in a manner that is easily understood. It is important to always review and edit the SOD for errors, grammar, and punctuation, and for clarity prior to issuance. It is strongly encouraged to utilize spelling and grammar check features while writing the SOD, but use of this feature does not replace the need to proof read the document prior to issuance.

When writing the citation, the goal is to be clear to the reader, which may include individuals outside of RCS or entity staff (i.e., the public, law enforcement, administrative law judges, etc.). Organize facts into headings, topics, or concepts (i.e., issues, units/halls/wings/, residents, etc.). Underlining or placing the single angle symbol (<) at the beginning and at the end (>) of the heading is acceptable. Below is an example of how this would look with infection control topics:

<Hand Hygiene>
<Communicable Disease Outbreaks>
<Catheter Care>
<Linens>

Or by rooms/units/wings/halls, or by resident:

Rooms	Halls/Wings	Resident
<Room 403> <Room 222>	<Rose Corridor> <Lily Corridor>	<Resident 3> <Resident 6>

Below are additional formatting guidelines:

- Use one space after a period.
- Use upper case letters when using proper names, titles, or acronyms (i.e., Resident 4, the Nursing Assistant (NA), etc.).

See the section on 'Styles' for more information.

The regulatory staff ***must***:

- Correlate each deficiency to a statutory or regulatory requirement.
- Use simple sentence structure to keep sentences short.
- Do not bold or type in all upper-case format the statement: 'Findings included…'
- When referencing an entity's policy, this should be listed first, directly under 'Findings included…'
- Document the most serious outcome or potential outcome first, when applicable (after an entity's policy reference if used).
- Document all relevant facts in a logical order that supports the seriousness of the situation.
- Include the date and time of all observations and interviews used to support a finding of non-compliance.
- Use gender-neutral pronouns, as able. For example, "they, them, or theirs." This is a particular consideration with a small number of residents residing under the care of the entity, as it helps protect their identity.
- Use the date of the record in mm/dd/yyyy format (e.g., 03/04/2024) when used to support a finding of non-compliance.
  - If the record has no date, note that the document is undated. Including the date the record was reviewed is only required if relevant to the non-compliance.
  - Use 'open' or 'closed' when referring to the records of current or discharged residents.
- Only include diagnoses that are relevant to the failed practice. Use caution when including diagnoses that could identify a resident.
- Write each deficiency citation as a stand-alone citation, using past-tense active voice.

Example of past-tense active voice

✗ " The caregiver was reprimanded by the nurse. "

✓ " The nurse reprimanded the caregiver."

- Use brackets to clarify details within a quote:

✓ "I punched the aide [Staff C, Caregiver] lots of times."

The regulatory staff ***must not***:

- Document what the entity did correctly.
- Include their own personal opinions, advice, comments, or assumptions.
- Copy and paste from one citation to another citation.
- Use the number (#) sign when referencing identifiers.
- Use the language 'it was determined.'
- Use the language 'not limited to.'
- Use vague terminology (e.g., approximately, seems, appears, did not always, timely, etc.).
- Use words that imply or state conclusions (e.g., only, just, unsatisfactory, unnecessary, throughout, on the second day, inadequate, etc.).
- Use 'All observations, interviews, and records reviews were completed on mm/dd/yyyy unless otherwise indicated.'
- Use irrelevant or extraneous words.
- Use the words 'and', 'but' or 'however' to connect two different ideas.

Example of avoiding the use of 'and'

✗ "The resident walked to the nurse to receive medication and they went to the activity room to listen to the news."

✓ " The resident walked to the nurse to receive medication. The resident went to the activity room to listen to the current news."

1. Styles

Abbreviations & Acronyms

- Do not use abbreviations or acronyms if only used once in the deficiency citation.
- All abbreviations and acronyms must be explained the first time used.

Abbreviation example: milligrams (mg)
Acronym example: Basic Life Support (BLS), or Two times a day (BID)

- Only clarify the abbreviation/acronym the first time used in the deficiency citation.
- Acronyms and abbreviations must be used consistently throughout the deficiency citation and throughout the SOD document, even when written by more than one individual.
- Only use acronyms and abbreviations that are generally accepted within long-term care settings.
- Do not use an acronym or abbreviation when it is generally known to mean something different.

Examples:

- Physician Assistant (PA)
- By mouth (po)
- WA State Name and Date of Birth (WNDOB)
- Background Inquiry (BGI)
- Fingerprint-based check (FBC)

- Provider A (PA)
- Physician's Orders (PO)
- Name and date of birth background check (NDBOBBC)
- Background Check (BGC)
- National fingerprint background check (NFBC)

Commas

- Commas are used to separate words and phrases to avoid confusion or to clarify. They can indicate a pause where you want the reader to take a breath.

Example: Parts of a regulatory staff's responsibilities include off-site preparation, on-site investigation, and off-site post activities.

- Do not put the comma before the last conjunction in a series if a key part of the series needs a conjunction.

Example: Resident 4 had orange juice, toast, and ham and eggs for breakfast.

Dash/Hyphen

- Use a dash to separate phrases in a sentence that are included to explain or qualify a statement.

> Example: Staff E, Caregiver, stated they began their shift at 9:00 a.m. – three hours later than scheduled.

- Use a hyphen to join modifiers.

> Example: Performing the responsibilities of a regulator has the potential to be a high-stress job.

Dates

- Use the eight-digit format for dates (e.g., mm/dd/yyyy).

> Example: 03/05/2024

- Spell out the name of the month when it stands alone or with only the year (no date included). Do not place a comma between the month and year (e.g., Month yyyy).

> Example: The background check for Staff F, Provider, was due in November 2023.

Ensure/Insure

- 'Ensure' means to guarantee.

> Example: It was everyone's job in the facility to ensure each of the staff assisted with resident safety.

- 'Insure' means to protect by issuing an insurance policy.

> Example: Insure yourself against liability and damages when driving a car.

Exclamation Marks & Upper-Case Letters

- Avoid the use of exclamation marks and ALL UPPER-CASE LETTERS.
- Use upper case letters to begin sentences, for proper names, identifiers, and acronyms.

Farther/Further

- Farther is used when referencing physical distance.

> Example: Resident 12 walked farther today than yesterday in the therapy pool.

- Further is used when referencing a figurative distance, or to a greater degree or extent.

> Example: The regulator probed further into the resident's concerns with more observations and interviews.

Fewer/Less

- Use 'fewer' when referring to a number and with plural nouns.

> Example: Staff A, Caregiver, supervised fewer than five residents during the activity.

- 'Less' refers to a degree or amount. Use 'less' with singular nouns.

> Example: Staff D, Licensed Nurse, told Staff B, Caregiver, that the afternoon session would contain less time to complete the on-line training.
> **Less is used in the context of a smaller degree or amount.*

Medical Jargon

- If a medical diagnosis is included in a statutory reference without explanation, then the diagnosis has been deemed "plain talk" rather than jargon and requires no additional explanation (e.g., tuberculosis).
- When referring to the Minimum Data Set (MDS), use the MDS language (e.g., independent, dependent, supervision, etc.).
- Avoid the use of medical jargon, as the readers may not understand the intent or meaning. If using jargon, it must be explained.

> Examples: Cardiac (heart related), dementia (a progressive condition that affects the brain), diabetes (a condition that affects blood sugar levels), Hoyer lift (a device used to assist with safely transferring a resident)

- When referencing medications, use generic terms that describe the medication's purpose.

> Example: Resident 4 did not receive their pain medication as ordered.

- If it is necessary to use the name of the medication, describe the purpose of the medication in parenthesis.

> Example: Resident 4 did not receive their morphine (a medication used for pain management).

None (use of the word)

- The word 'none' is a noun, which requires a singular verb. Think of 'none' as 'no one' or 'not one.'

> Example: Resident 4's fall incident report was requested on mm/dd/yyyy, none was provided.
> **'None' in this sentence is singular, not plural.*

Quotation Marks

- Only quote information if it is exact, accurate, and strengthens the citation.
- Keep quotes to a minimum.
- Ensure quotes are documented in their entirety without breaking the sentence up into clauses.
- Use asterisks to fill in a word of profanity if used within a quote (e.g., s**t, son of a b***h).
- Place quotations marks outside, or after, almost all punctuation marks (e.g., "…called out.")
- The dash, semicolon, question mark, and exclamation point go within the quotation marks when they are part of the quoted matter only. They go outside the quotation marks when they apply to the whole sentence.
- Use brackets to clarify details within a quote:

> "I punched the aide [Staff C, Caregiver] lots of times."

That/Which

- No punctuation is needed when using the word 'that.'

> Example: The bingo prize that Resident 4 wanted was gone.

- When writing the word 'which,' use a comma.

> Example: The bingo prize that Resident 4 wanted, which would be therapeutic, was gone.

Time & Time Ranges

- Use standard, or 12-hour, time format with the hour, minutes, followed by the abbreviation a.m. or p.m. (or AM/PM or am/pm. Any of these formats are acceptable, as long as they are used consistently throughout the citation.)
- Do not write 9:00 a.m. *in the morning*, or 8:15 p.m. *in the evening*, as this is redundant.
- Do not use military or 24-hour clock time.
- Do not use the word 'approximately.'

Writing Numbers

- Always write out numbers when used at the beginning of a sentence.
- Write out numbers one through nine.
- Write numbers 10 and greater in numerical form (e.g. 24, 33, 104, etc.).

Exceptions include:

- Recording measurements

0.5 inches, 1.0 centimeters, etc.

- Recording dates and times
- Documenting scope and universe

1 of 3 residents (Resident 4)
2 of 4 clients (Clients 2 and 4)

- Documenting identifiers

Residents 1-3
Residents 1 to 3

Residents 1, 2, and 3

D. Principle 3: Components of a Deficiency Citation

A SOD consists of a **regulatory reference**, a **deficient practice statement (DPS)**, and **relevant findings** (also referred to as evidence). The specific objective facts gathered through data collection are the evidence that supports each DPS. The data answers the questions who, what, when, where, and/or how for each deficient practice and illustrates the entity's noncompliance.

EXAMPLE: Components of a SOD

WAC 388-78A-2160 Implementation of negotiated service agreement.

Regulatory Reference	The assisted living facility must provide the care and services as agreed upon in the negotiated service agreement to each resident unless a deviation from the negotiated service agreement is mutually agreed upon between the assisted living facility and the resident or the resident's representative at the time the care or services are scheduled.

This requirement was not met as evidenced by:

Deficient Practice Statement (DPS)	Based on observation, interview, and record review, the entity failed to implement a care plan for toileting assistance for 1 of 3 sampled residents (Resident 1). This failure placed the resident at risk for skin issues.

Findings included...

Relevant Findings (evidence)	Observation on 10/05/2023 at 10:05 AM... During an interview on 10/05/2023 at 9:26 AM... Record review of Resident 1's toileting assistance care plan, dated 08/08/2023, showed...

Note: Since the DPS serves as a summary statement of non-compliance, do not include a conclusion or summary statement at the end of the deficiency citation.

Regulatory Reference Includes:

- Applicable regulatory reference (federal tag number, WAC, RCW, CFR, etc.);
- The specific language from the aspects (sections and subsections) of the regulatory requirement the entity did not meet;
- An explicit statement that the "standard", "requirement" or "condition" was "not met."

Note: **STARS** adds all these components once the regulatory references are selected when developing the SOD. In **ASPEN**, this information must be added manually.

Deficient Practice Statement (DPS):

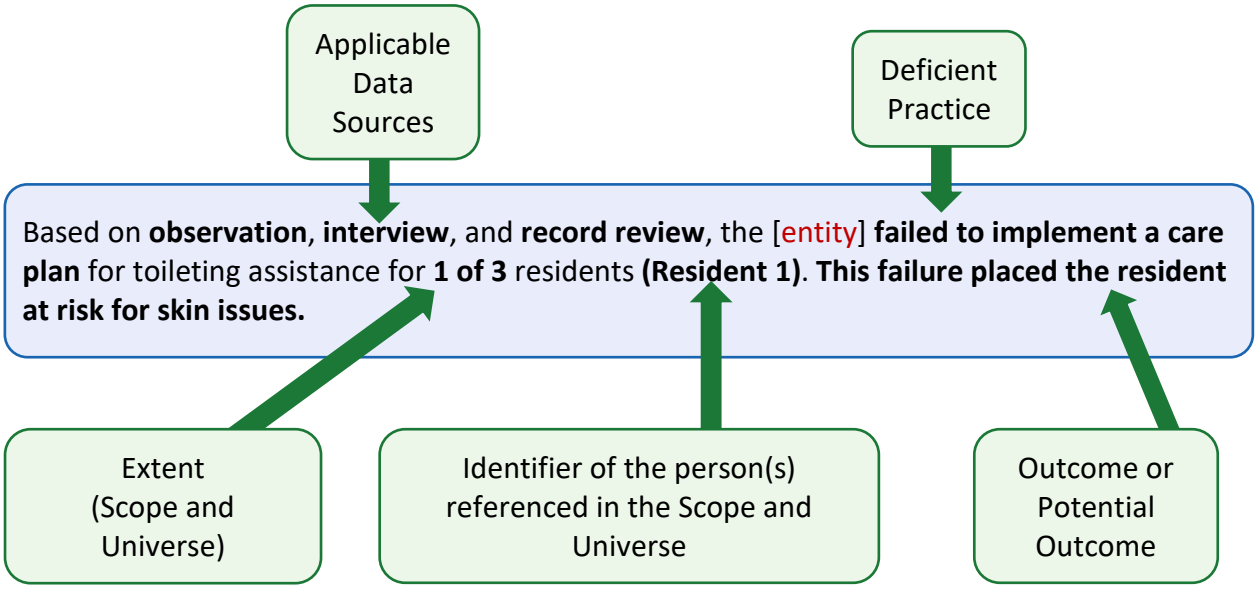
The DPS defines what actions the entity did or did not take without repeating the regulatory requirement. The specific action or inaction in the DPS must be described in concise clear terms so that the entity can determine why the noncompliance exists, and which part of the regulation was "not met." The DPS should be organized and flow in a logical manner relating to each part of the regulatory requirement with which the entity failed to comply.

Each DPS identifies the data sources collected during the regulatory process: observation, interview, and/or record review. The data sources documented in the DPS must be explained in the findings. The specific action(s), error(s), and lack of action (deficient practice) relative to the statutory or regulatory requirement must be included: "The entity failed to…"

The extent of the deficient practice (scope/universe) relates to 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.

***Note: All deficiency citations **must** be supported by at least **two of the three** data sources.*

EXAMPLE: 5 Components of a DPS



Only include the data sources contained in the working papers as findings (evidence). Each evidence category type (obervations, interviews, and record reviews) must have corresponding evidence in the working papers if they are included in the DPS. In the example below, the evidence gathered was based on observations and interviews, so record reviews are not listed.

Based on **observation** and **interview**, the [entity] **failed to implement a care plan** for toileting assistance for **1 of 3** residents **(Resident 1)**. **This failure placed the resident at risk for skin issues.**

EXAMPLE: Scope and Universe

The scope is the number of residents, specific environmental areas, or failed practice issues actually affected by the entity's noncompliance.

The universe is the total number of sampled residents, specific environmental areas, or failed practice issues that could potentially be affected.

Based on **observation** and **interviews**, the [entity] **failed to implement a care plan** for toileting assistance for **1 of 3** residents **(Resident 1)**. **This failure placed the resident at risk for skin issues.**

The universe can apply to any individual, environmental area, or issue:

1 of 2 bathrooms (Bathroom A)	*1 of 3 courtyards (Courtyard C)*
2 of 5 resident rooms (Resident 4 and 6)	*1 of 4 pets (Pet B)*

The identifier of the deficient cases referenced in the scope of the deficient practice:

- Singular: Client 1, Resident 8, Staff C, Room 107.
- Multiple: Residents 2, 45 and 18, or Clients 1, 2, and 3, Utility Rooms in Halls 2 and 5.

Note: Do ***NOT*** use the # symbol in front of the identifier number.
Do not use ranges (i.e., Residents 1-10). Each must be separately identified.

When determining the universe, it is important to determine the scope of an issue. If an identified concerns affects all residents within the universe, this may be considered a "system wide failure." In these instances, document a separate statement in the outcome or potential outcome statement showing this is a system wide issue.

In the correct example below, the outcome or potential outcome statement may be written as: "This was a system wide failure for medication management of residents with diabetes."

Example of System Wide Failure
Diabetic Management

Universe of diabetic residents in the facility is 4.
Scope of diabetic residents affected by the deficient practice is 2.
This would not be considered a system wide failure.

Universe of diabetic residents in the facility is 4.
Scope of diabetic residents affected by the deficient practice is 4.
This would be considered a system wide failure.

Confidential Identifiers are used in a good faith effort to maintain confidentiality and protect the identity of those documented in the citation(s). The identifiers can be letters or numbers. The identifiers in the DPS **must** match those identifiers in the "Findings included…".

Whenever possible, if a follow-up visit finds noncompliance for the same individual as in the original regulatory visit, reassign the same identifier. If it is not possible to use the same identifier, use a different set of letters/numbers for follow-up visits so that in the event of a hearing, the same identifier is not used for two different individuals correlating to the original regulatory visit.

The outcome(s) or potential outcome(s) statement (also referred to as the risk statement or "so what" statement) describes the specific results and consequences of the entity's noncompliance with a statutory or regulatory requirement. The outcome statement reflects actual or potential negative outcomes including system failure(s), failure to maintain, or improve resident centered care and services, and actual harm, imminent danger, or Immediate Jeopardy.

EXAMPLE: Outcome(s)/Risk(s) or Potential Outcome(s)/Risk(s)

Actual Outcome /Risk	•This failure resulted in the resident being bed bound for three months. This caused harm to Resident 13. •This failure resulted in the clients developing a heat related illness. This is a system failure.
Potential Outcome /Risk	•This failure placed residents at risk for being bed bound for an extended period. •This failure placed clients at risk of developing a heat related illness.

Section Overview Glossary of Terms Acronym List Table of Contents

Relevant Facts and Findings

A fact is an actual occurrence: something known to exist or to have happened through observation, interview, and possibly record review. Facts are required to support the determination of failed practice. Without facts, the determined conclusion could be viewed as an assumption about the entity's compliance.

The findings must describe the facts with enough detail to support the deficient practice. Only include facts relevant to support the finding of deficient practice. All identifiers and data sources included in the DPS must be documented in the findings and must be used consistently throughout the document.

The facts and findings need to be ordered in a logical sequence of events. Place the order of events chronologically when possible. The facts and findings must include the date, time, and when pertinent, the location of the data collection. The organization of the facts and findings must clearly convey to the reader the events that resulted in a deficiency citation.

When a staff member is referred to in the facts and findings for the first time, document the staff's identifier followed by their specialty/job position (e.g., Staff C, Provider; Staff E, Department of Nursing Service). It is permissible to include the staff's specialty/job position in the DPS, prior to the relevant facts and findings. In either scenario, once documented, only the identifier is required throughout the rest of the citation when referring to these staff members.

Note: If a staff person requests to be kept anonymous when interviewed, identify them in the SOD as a Collateral Contact (CC) and **do not** include their information in the identifier list. See 'Confidential Identifier Lists' for more information.

Documenting Interviews

- Document the date, time, and if applicable, the location of the interview.
- Use the verb "stated," "said," "indicated," "reported," "answered," or "replied."
- Use the verb "stated" for direct quotes with quotation marks.
- Use "stated that" for paraphrasing general intent.

Referencing an Entity's Policy

- Place the facility policy at the beginning of the citation, directly following "Findings included…"
- Reference only the part(s) of the policy that supports the citation.
- Only the policy title should be in quotes (""), not the policy directives being included.
- Do not identify which section of the policy from which you are quoting the material.

Examples of documenting observations, interviews and record reviews are on the following pages.

Observation Examples:

Observation on 04/05/XXXX at 10:15 AM, showed that Bathroom A's water temperature, as displayed on the facility's thermometer, was 114.7 degrees Fahrenheit (ºF).

Observations on 01/07/XXXX at the following times showed Client 3 picking things up from the floor and holding on to them:

- At 7:42 AM, in the entry hallway, picked up a gum wrapper.
- At 1:20 PM, on the backyard patio, picked up a piece of gravel.

Observation on 11/01/XXXX at 12:47 PM, inside Kitchen 2's walk-in refrigerator showed an opened, undated container of cream cheese spread, a bowl covered in plastic wrap that contained unidentified liquid with no date, and an unlabeled, undated white condiment bottle containing a white liquid substance. A bowl of melted ice cream was uncovered, unlabeled, and undated on the bottom shelf, below a tray of bacon.

Interview Examples:

During an interview on 01/04/XXXX at 2:44 PM, Resident 5 **stated that …**

Interview on 02/14/XXXX at 11:05 AM, Staff M, Home Care Aide (HCA), **said …**

In an interview on 08/24/XXXX at 4:55 PM, Client 3 **reported** …

On 01/26/XXXX at 1:35 PM, **Collateral Contact** reported …

Interview on 11/20/XXXX at 10:25 AM, Resident 2 **stated, "[direct quote]."**

Can also use:	**…indicated**	**…replied**	**…answered**

Record Review Examples:

Dated policy using one piece of information from the policy:

Record review of the facility's policy titled, "Caring for Individuals with Dementia," dated 07/31/XXXX, showed that if the resident refuses, staff are required to re-approach the resident three times.

Undated policy using three or more pieces of information from the policy:

Record review of the facility's undated policy titled, "Caring for Individuals with Dementia," showed that the requirement for facility staff is to re-approach the resident three times when the resident refuses, is resistive to care, communicated with inappropriate verbal comments, and/or becomes aggressive.

Revised policy using one piece of information from the policy:

Record review of the facility's policy titled, "Caring for Individuals with Dementia," revised on 07/31/XXXX, showed that staff are required to re-approach the resident three times if the resident refuses.

No existing policy:

Record review of the electronic medical record policy showed that the facility had no process for identifying staff member's electronic signatures.

Policy not provided as requested:

Record review of background checks showed that the facility did not provide policies as requested for staff background checks who are volunteers.

E. Principle 4: Relevance of On-Site Correction of Findings

1. Federal Programs (NH, ICF/IID)

For federal programs (**NH** and **ICF/IID**), the entity develops a plan of correction, which includes the date the entity asserts they were or will be back in compliance with the regulatory requirement.

2. Community Programs (AFH, ALF, ESF)

The Department must first determine if the violation meets the criteria for a consultation:

- Corrected to the satisfaction of the Department while regulatory staff is on-site and prior to the exit conference.
- Is not recurring/repeated, meaning it is not a violation or deficiency that was cited under the same regulatory reference in one of the two most recent preceding regulatory visits (inspections, investigations, or evaluations); and
- Did not pose a significant risk of harm or actual harm to a resident.

If all criteria are met, write the deficiency as a consultation. Include the statement "This deficiency was corrected on-site at the time of visit" following the DPS. Consultations are never written for care and services or safety areas that pose a significant risk of harm or have caused actual harm to a resident. A Consultation is a violation that does not require an attestation (**AFH, ALF, ESF**).

If the criteria are not met but was corrected while the regulatory staff was on-site, write the deficiency as a citation. Include the statement "This deficiency was corrected on-site at the time of visit" following the findings section.

Refer to Principle 10 for the components of how a consultation is documented.

F. Principle 5: Interpretive Guidelines – Federal Programs (NH, ICF/IID)

In Federal regulations, the deficiency citation describes how the entity failed to comply with the statutory or regulatory requirements. The deficiency citation does not write to the failure of complying with the guidelines or the interpretation of those statutory or regulatory requirements.

Various appendices to the Federal SOM contain "Interpretive Guidelines" or "Guidance to Surveyors." These Guidelines were designed to assist regulators in developing a better understanding of the regulatory requirements, how to apply these requirements in a consistent manner across entities, and to suggest pathways for inquiry.

Although regulators must use the information contained in Guidelines, they must be cautious in their use. Guidelines do not replace or supersede the law or regulation. Therefore, the Guidelines may not be used as the basis for a citation. However, the Guidelines do contain authoritative interpretations and clarifications of statutory and regulatory requirements. Interpretive guidelines can include professionally recognized standards and assist regulators in making determinations about an entity's compliance with requirements. When an entity is found to violate a requirement because of its connection to a professionally recognized standard, the regulator must document such on the CMS-2567 form.

Regulators should carefully consider how the practices of the entity relate to the designs within the Interpretive Guidelines. Then, compare the entity's practice to the specific language and requirement of the regulation before determining that a deficiency exists.

G. Principle 6: Citation of State or Local Code Violations – Federal Programs (NH, ICF/IID)

The entity's failure to comply with State or local laws or regulations is not documented on the CMS-2567 form except when the Federal regulation requires compliance with State or local laws. When the authority having jurisdiction for that State or local law has made a decision of noncompliance and has imposed remedies that have been sustained through the hearing process (such as removal of the license to operate), the CMS-2567 form should note the remedies imposed.

H. Principle 7: Cross-References

Cross-referencing is most effective when the two deficiency citations have a direct cause and effect relationship to the deficient practice described in both deficiency citations. In all instances, each deficiency citation must contain relevant facts to demonstrate noncompliance for the referenced statutory or regulatory requirements independent of any other deficiency citation referenced. Each citation must be able to stand on its own.

When cross-referencing, note the references after the relevant facts and findings. See Appendices for more information.

Example: Refer to WAC 388-78A-2210(1)(b).

I. Principle 8: Conditions of Participation (COP) Deficiencies – ICF/IID Only

The COP citation includes a statement(s) of the entity's deficient practice(s) with findings included to support the determination of noncompliance with a condition level requirement. The findings may be incorporated either by cross-references to those requirements, which must be corrected to find the COP in compliance, or by a narrative description of the individual findings. The COP citation includes ONLY those requirements that MUST be corrected to achieve compliance with the COP.

If a COP is determined to be deficient, the SOD identifies the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these secondary requirements may be referenced under the COP citation.

J. Principle 9: Citations With More Than One Regulatory Reference

If the deficient practice can be applied to more than one regulatory reference, then the deficient practice must be evaluated for the regulatory reference that most represents the deficient practice. The regulatory reference should contain the language that best demonstrates what the entity failed to comply with. Each deficiency citation must reference only the most applicable WAC and/or RCW and must not contain multiple regulatory references under the same citation.

If the deficient practice can be associated with more than one regulation and each regulation can be independently supported with sufficient facts of noncompliance, each citation must be written separately as standalone citations. Cross-referencing may be applied between the citations only when there is a direct cause and effect relationship between the two citations.

The program specific WACs are what grant RCS regulatory authority over an entity. However, there are WACs outside of those program specific WACs that may apply. In these instances, the program specific WAC will direct the entity to comply with those requirements.

To properly cite regulations that fall outside RCS' regulatory authority, the specific section of the program specific WAC which references the outside WAC must be included in the deficiency citation. Then the outside WAC showing how the entity did not meet the requirement must also be present in the deficiency citation.

Program Specific WACs:	
• **AFH:** Chapter 388-76 WAC	• **CCRSS:** Chapters 388-101 WAC and 388-101D WAC
• **ALF:** Chapter 388-78A WAC	• **ESF**: Chapter 388-107 WAC

See next page for examples for each community program.

Examples of citing WACs outside of RCS' regulatory authority

AFH	WAC 388-76-10415(1) directs the entity to comply with Chapter 388-112A WAC. In this instance, 388-76-10415(1) would be included indicating compliance is required with 388-112A WAC and then the specific sections of 388-112A WAC would be included to show how the entity did not meet the requirements.
ALF	WAC 388-78A-2300(2) directs the entity to comply with Chapter 246-215 WAC. In this instance, 388-78A-2300(2) would be included indicating compliance is required with 246-215 WAC and then the specific sections of 246-215 WAC would be included to show how the entity did not meet the requirements.
CCRSS	WAC 388-101D-0060(2)(c) directs the entity to comply with Chapter 246-840 WAC. In this instance, 388-101D-0060(2)(c) would be included indicating compliance is required with 246-840 WAC and then the specific sections of 246-840 WAC would be included to show how the entity did not meet the requirements.
ESF	WAC 388-107-0090(2)(b) directs the entity to comply with Chapter 388-113 WAC. In this instance, 388-107-0090(2)(b) would be included indicating compliance is required with 388-113 WAC and then the specific sections of 388-113 WAC would be included to show how the entity did not meet the requirements.

K. Principle 10: Components of a Consultation – AFH, ALF and ESF only

A consultation consists of regulatory reference, and a deficient practice summary. The deficient practice summary for a consultation is brief (two to four sentences) indicating what the failed practice was. The actual or potential outcome may also be documented. A Consultation is a violation that does not require an attestation.

In order to consider writing a deficiency as a consultation, the Department must first determine if the violation meets the criteria for a consultation:

- Corrected to the satisfaction of the Department while regulatory staff is on-site and prior to the exit conference.
- Is not repeated/recurring, meaning it is not a violation or deficiency that was cited under the same regulatory reference in one of the two most recent preceding regulatory visits; and
- Did not pose a significant risk of harm or actual harm to a resident.

If all criteria are met, write the deficiency as a consultation. Include the statement "This deficiency was corrected on-site at the time of visit" following the deficient practice summary. Consultations are never written for care and services or safety areas that will impact the residents (e.g., fire safety, medications, background check information, etc.).

L. Principle 11: Repeated/Recurring, Uncorrected, and/or Previously Cited – Community Programs Only

This principle is for **AFH**, **ALF**, **CCRSS** and **ESF** guidance only. Refer to the definitions in the Glossary of Terms section in this manual for a better understanding of recurring, repeated and uncorrected terminology. Discuss these patterns of failed practice/deficiencies with your field manager and Compliance Unit/Enforcement Specialist. The findings documented in the deficiency citation must be of substantially the same problem for the exact same WAC/RCW section(s) within the preceding 24 months for **CCRSS** and the preceding 36 months for **AFH**, **ALF** and **ESF**.

The following is guidance on specific language to document for recurring, repeated, and uncorrected or previously cited deficiencies for SODs. When noting recurring/repeated and/or uncorrected dates, order dates from most current to oldest. Add this documentation at the end of the citation findings. See Principle 11 examples in the Appendices. Do not include current citation dates in the new SOD.

AFH	ALF	CCRSS	ESF
• Repeated or uncorrected • Preceding 36 months	• Recurring or uncorrected • Preceding 36 months	• Repeated or uncorrected • Preceding 24 months	• Recurring or uncorrected • Preceding 36 months

How to write in the SOD Repeated/Recurring Deficiencies:

Use the word 'repeated' or 'recurring' when citing a previous deficiency. The use of these words must be used only when one or more of the following criteria are met:

- The Department previously cited a violation under the same section of WAC or RCW for substantially the same problem following any type of inspection or investigation on *two or more* occasions within the preceding 24 months for **CCRSS** or the preceding 36 months for **AFH**, **ALF**, and **ESF**.
- 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 or investigation within the preceding 24 months for **CCRSS** or the preceding 36 months for **AFH**, **ALF**, and **ESF**.

See following page for examples.

When cited two or more times:

- This is a repeated (or recurring) deficiency previously cited on [add previous cited date(s) in order of most current to oldest].

Uncorrected Deficiencies:

- This is an uncorrected deficiency previously cited on [most recent previously cited date] for subsection(s).

Partially Uncorrected Deficiencies:

- This is an uncorrected deficiency previously cited on [most recent previously cited date].

Previous Consultation are not considered citations:

- The AAGs have determined that consultations and citations are different and if a home receives a consultation for a WAC violation and then has a later citation under the same WAC, they would not be considered previously cited and this would not be considered a recurring or repeated violation. When determining whether or not to issue a citation or impose a remedy, the department should not consider these violations recurring solely based on a previous consultation but rather as first-time offense.

Repeated/Recurring Deficiencies within the prior 36 months (AFH, ALF, ESF) or 24 months (CCRSS) and Uncorrected Deficiencies:

- This is a repeated [or recurring] deficiency on [previous cited date] and an uncorrected deficiency previously cited on [most recent previously cited date].

Part III: Additional Guidance

A. Nursing Tasks

Purpose

The inspection, certification evaluation, survey, certification, and investigation activity RCS staff conduct while on-site do not always include a Registered Nurse (RN) as part of the team. Some tasks may require an RN to complete a clinical assessment (e.g., skin, or wound assessments). The purpose of this SOP is to inform staff which tasks the RN must conduct during on-site visits, when staff can consult with an RN to ensure regulatory work is completed, and alternatives for staff while on-site when no RN is available.

Procedure

1. Registered Nurses will:
   a. Conduct any needed assessments related to observation of skin or anatomical structures of the resident's breasts, genitalia, and buttocks.
   b. Observe tasks completed by licensed nursing staff if concerns arise.
2. 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.
3. Clearly document in the working papers if/when consultation occurs and by what method.
4. During **NH** surveys and **NH** complaint investigations, an RN will observe several modes of medication administration such as oral, intravenous, subcutaneous, etc.

B. Other Regulatory Requirements

Purpose

Licensed settings are required to meet all rules and laws of the state in addition to RCS licensing statutes and rules. For example, in some settings, RCS has rules for sewage systems and reporting notifiable conditions. The Department of Health (DOH) also has rules for sewage systems and notifiable conditions. Although staff are generally not required to verify the entity is in compliance with rules and laws regulated by other agencies during an inspection, staff may observe conditions that require reporting to other regulatory authorities. These situations include but are not limited to:

1. Observable or reportable:
   a. Crime (law enforcement [LE])
   b. Abuse or neglect (Adult Protective Services [APS], Department of Child, Youth and Families [DCYF])
   c. Unsafe working conditions (Labor and Industries [L&I])
   d. Fire safety or evacuation risks (Office of the State Fire Marshal [OSFM])
   e. Well failure (DOH)
   f. On-site sewage system (septic) failure (DOH)
   g. Fraud (Office of the Attorney General Medicaid Fraud Control Division [MFCD]; DSHS Office of Fraud and Accountability [OFA])
   h. New, unpermitted construction (Construction Review Services [CRS]; local building official)
2. Absence of:
   a. Industrial Insurance/L&I registration (L&I)
   b. Medical test site license (DOH)
   c. Other professional license (Department of Licensing [DOL], DOH)
   d. Reporting “notifiable conditions” (DOH)

Procedure

1. Regulate according to WACs when applicable.
2. Notify your FM to determine if a referral to another regulatory authority is needed.
3. Report findings to the Complaint Resolution Unit (CRU), following requirements of SOP Chapter 4. CRU will make a referral to any other applicable authority.
4. Report emergent situations directly to the appropriate authorities.

Part IV: Appendices

A. Resources

1. DSHS Administrative Policy 2.11 – Plain Talk: Clear Written Communications
2. Center for Medicare and Medicaid, State of Operations Manual Exhibit 7A Principles of Documentation, undated
3. Office of the Governor, Plain Talk Guidelines
4. Office of the Governor, Plain Talk Resources
5. Executive Order 23-02 – Plain Language
6. Washington State Employees LGBTQ + Business Resource Group, Use of Pronouns in External Communications
7. Deficiency Citation Analysis Tool

   The use of the Deficiency Citation Analysis Tool (DCAT) assists in writing each deficiency citation for each program. The DCAT addresses the regulatory reference, the deficient practice statement, and the findings.

   Regulatory staffs' and Field Managers' utilization of the DCAT will provide a quality assurance assessment of the documentation in the citation to ensure all of the components of a deficiency citation are included. The DCAT tool is located on the next page.

   The original writer of the citation(s) or the team will read and edit each citation for errors, clarity, and precision of meaning. Accomplish this by using the DCAT, reading aloud, using spell check features, and adhering to plain language. Then, the Statement of Deficiency is complete and ready to submit to the field manager.

Deficiency Citation Analysis Tool (DCAT)

Tag # or WAC	Tag # /WAC		Tag # /WAC		Tag # /WAC		Tag # /WAC		Tag # /WAC		Tag # /WAC		Tag # /WAC		Tag # /WAC	
Document The Tag or WAC For Each Citation	Tag #/WAC		Tag #/WAC		Tag #/WAC		Tag #/WAC		Tag #/WAC		Tag #/WAC		Tag #/WAC		Tag #/WAC	
+ is yes, - is no	+	-	+	-	+	-	+	-	+	-	+	-	+	-	+	-
Evidence: Each Deficient Practice Statement (DPS) Has Corresponding Findings																
Based On Statement (Data Sources)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Failed To Statement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Extent of Deficient Practice: Scope	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Universe	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identifiers (Confidential)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
So What Statement/Potential/Actual Outcome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Plain Language Describing Regulatory Violation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Clearly Understood What The Facility Is To Fix	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The Regulation IS NOT Repeated	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
The DPS Is NOT A Cut And Paste From Another Tag in the SOD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
State/Local Code Reference, If Applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Findings/Facts																
Documented Statement: Findings Included…	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Who	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
What	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
When	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Where	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Potential or Actual Outcome/Risk Statement	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Observations/Interviews include Date, Time	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Document Reviews Include Date(s) Of Data Entry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Logical Organization Of Facts/Chronological Order	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Applicable To The Selected Regulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Written In Plain Language With Active Voice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Free Of: Irrelevant Diagnoses/Medical Jargon	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Remarks/Advice	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vague/Abstract Terms	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irrelevant Words/Run-on sentences	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Assumptions/Conclusions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Spelling/Grammar Errors	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Findings Included Match the DPS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Click or tap here to enter text.

Reviewer:

Click or tap to enter a date.

Date Reviewed:

Click or tap here to enter text.

Residential Setting's Name and Date of Final SOD:

B. POD Examples

1. Principle 3: Components of a Deficiency Citation

a. AFH

Regulatory Reference
WAC 388-76-10225 Reporting requirement. (2) When there is a significant change in a resident's condition, or a serious injury, trauma, or death of a resident, the adult family home must immediately notify: (a) The resident's family; (b) The resident's representative if one exists; (c) The resident's health care provider; **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on observation, interview and record review, the provider failed to report a serious injury (bruise to the face) to the resident's representative and health care provider for 1 of 2 residents, (Resident 1). This failure resulted in Resident 1 not receiving informed decisions by their representative and health care provider.
Relevant Facts/Findings
Findings included… Observation on 01/01/XXXX at 1:00 PM, showed Resident 1 had a round, red, yellow, and purple bruise on the right side of their face measuring 0.6 by 0.4 inches. During an interview on 01/01/XXXX at 2:00 PM, Staff C, Caregiver, stated that they informed the provider about the bruise but were unsure if the resident's representative and health care provider were notified. Record review of Resident 1's records, dated 12/18/XXXX through 01/01/XXXX, showed no documentation that Staff A, Provider, or Staff C reported the injury to the resident's representative and health care provider were notified. During an interview on 02/01/XXXX at 9:09 AM, Collateral Contact 1 (CC1), Health Care Provider, stated that there was no record of the home calling to report the bruise. During an interview on 02/01/XXXX at 10:00 AM, Collateral Contact 2 (CC2), resident's legal representative, stated that the home did not notify them about the bruise. During an interview on 02/01/XXXX at 11:30 AM, Staff A stated that they did not notify the resident's representative or health care provider of Resident 1's bruise.

b. ALF

Regulatory Reference
WAC 388-78A-2450 Staff. (2) The assisted living facility must: (b) Verify staff persons' work references prior to hiring; (3) The assisted living must: (d) maintain the following documentation of the assisted living premises, during employment, and at least two years following termination of employment: (A) Training required by chapter 388-112A WAC; (iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on record review and interview, the facility failed to verify and maintain reference check documentation for 4 of 8 sampled staff members (Staff B, D, E, & G) in each of their personnel files. This failure placed residents at risk of receiving care from unqualified staff members.
Relevant Facts/Findings
Findings included… Record review of the facility's policy titled, "Steps to Hiring Quality Staff", dated 06/09/XXXX, showed staff reference checks were to be completed prior to hire. A copy of the reference checks were to be maintained in each of the staff member's personnel file. Record review of Staff B, D, E, and G's personnel files on 03/25/XXXX, showed: • Staff B, Caregiver, was hired on 08/15/XXXX and contained three blank reference check forms; • Staff D, Caregiver, was hired on 08/24/XXXX and contained three blank reference check forms; • Staff E, Licensed Nurse, was hired on 07/06/XXXX and contained one blank reference check form; • Staff G, Caregiver, was hired on 07/02/XXXX and contained no reference check forms. During an interview on 03/25/XXXX at 4:00 p.m., Staff A, Administrator, stated that the reference check forms for Staff B, D, E were not completed. Staff A stated that they were unable to locate the reference check form for Staff G.

c. CCRSS

Regulatory Reference
WAC 388-101D-0125 Client rights. (3) The right to privacy, including the right to receive and send private mail and telephone calls; **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on observation, interview, and record review, the provider failed to allow privacy during incoming and outgoing phone calls for 1 of 3 clients (Client 1). This failure resulted in intruding on a client's right to privacy.
Relevant Facts/Findings
Findings included… Observation on 06/21/XXXX at 10:05 a.m., showed Client 1 was on the phone. Client 1 told staff to whom they were speaking with. Record review of Client 1's record, dated 01/02/XXXX showed a "Phone Log" with columns labeled as "Date," "Who Called," "Number," "Did They Talk," and "Staff" with a selection box for incoming and outgoing phone calls. During an interview on 06/21/XXXX at 2:28 p.m., Staff H, Nurse Aide Registered, stated that staff were to log each client's phone calls on each of their personal phone logs. During an interview on 06/22/XXXX at 10:15 a.m., Staff B, Administrator, said all clients have a phone log with staff expectation to document incoming and outgoing phone calls. Staff B stated that the clients were not asked if staff could document their phone calls on a log.

d. ESF

Regulatory Reference
WAC 388-107-0370 Treatment services. The enhanced services facility must: (1) Provide for diagnostic and therapeutic services prescribed by the attending clinical staff that meet all of the resident needs identified in the person-centered service plan, to include mental health and chemical dependency treatment. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to provide mental health services in accordance with person-centered service plans for 2 of 6 sampled residents (Residents 3 & 5). This failure placed residents at risk of not having their mental health needs met.
Relevant Facts/Findings
Findings included… <Resident 3> Record review of Resident 3's admission paperwork, dated 08/11/XXXX, showed they were admitted on 08/11/XXXX with multiple mental health diagnoses and mood disorders. Record review of Resident 3's Person-Centered Service Plan (PCSP), dated 08/11/XXXX, showed Resident 3 was to receive mental health services from a qualified provider three times a week. During an interview on 10/19/XXXX at 11:26 a.m., Resident 3 stated that they had not seen a mental health provider (MHP) since admission to the facility. Record review of Resident 3's Care Notes, dated 10/19/XXXX, showed no documentation of a MHP visit. <Resident 5> Record review of Resident 5's admission paperwork, dated 08/15/XXXX, showed they were admitted on 08/15/XXXX, with multiple mental health diagnoses. Record review of Resident 5's PCSP, dated 08/15/XXXX, showed Resident 5 was to receive mental health services from a qualified provider three times a week. Record review of Resident 5's Care Notes, dated 10/19/XXXX, showed Resident 5 had a scheduled appointment with the MHP on 10/16/XXXX.

During an interview on 10/19/XXXX at 1:56 p.m., Resident 5 stated that they had an appointment to meet an MHP on 10/16/XXXX, but the MHP did not show up. Resident 5 stated that the MHP did not receive a request for a new appointment date.

During an interview on n 10/19/XXXX at 3:00 p.m., Staff C, Administrator, stated that neither Resident 3 nor Resident 5 have seen an MHP.

e. ICF/IID

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
W227	(Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) §483.440(c)(4) that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section, This STANDARD is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
W227	Based on observation, interview and record review, the facility failed to document objectives for a compulsive behavior on a Positive Behavior Support Plan (PBSP) for 1 of 6 sampled clients (Client 3). This failure placed Client 3 at risk of not having an unidentified behavior addressed through the PBSP.
Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
W227	Findings included… Record review of Client 3's Comprehensive Functional Assessment, dated 07/10/XXXX, showed Client 3 had a behavior of walking around picking things up from off the floor and holding onto them. Record review of Client 3's PBSP, dated 07/11/XXXX, listed one of Client 3's behaviors as "Compulsive scanning of the environment for objects out of place and needing to be picked up off of the floor." There was no individual program addressing this identified behavior. Observations on the following dates and times showed Client 3 picking things from off the floor and holding onto them: • 01/07/XXXX, at 1:42 p.m., at Building 2044, Room 204 picked up a gum wrapper. • 01/08/XXXX, at 7:34 a.m., at Seaside House picked up a shoe. • 01/09/XXXX, at 1:20 p.m., at Building 2033, Room 201 picked up a leaf. During an interview on 01/09/XXXX at 6:30 p.m., Staff L, Psychology Associate, stated that the PBSP did not contain objectives addressing Client 3's behavior of picking things from off the floor and holding onto them.

f. NH

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
F697	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
F697	Based on interview and record review, the facility failed to initiate non-medication related interventions prior to the administration of pain medication for 1 of 4 sampled residents (Resident 38). This failure placed the resident at risk for a lack of non-medication interventions to relieve ongoing pain.
Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
F697	During an interview on 04/11/XXXX at 11:22 a.m., Resident 38 stated, "I have pain in my back from a fall several years ago. I take pain medication, which takes the edge off. Truly, I am in constant pain." During an interview on 04/13/XXXX at 12:55 p.m., Resident 38 stated staff, "They [staff] offer warm blankets if I'm cold but not for pain in my back." Record review of Resident 38's pain assessment, dated 02/19/XXXX, showed non-pharmacological interventions as: offer a warm blanket, provide one to one care, offer assistance with repositioning and offer activities. Record review of Resident 38's Medication Administration Record (MAR), dated from 02/19/XXXX through 04/13/XXXX, showed no documentation of attempted non-pharmacological interventions for pain management. During an interview on 04/17/XXXX at 2:32 p.m., Staff V, Registered Nurse, said other than pain medication, they weren't aware of any additional interventions. During an interview on 04/18/XXXX at 9:20 a.m., Staff H, Director of Nursing Services, stated that non-pharmacological pain interventions were documented on the MAR. Staff H reviewed Resident 38's MAR for the months of March and April XXXX, and said there were no non-pharmacological pain interventions documented on the MAR.

2. Principle 4: Relevance on On-Site Correction of Findings

a. AFH

Regulatory Reference
WAC 388-76-10475 Medication Log. The adult family home must: (3) Ensure the medication log includes: (a) Initials of the staff who assisted or gave each resident medication(s); **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the home failed to initial the medication log for medications administered to 1 of 2 sampled residents (Resident 4). This failure placed the resident at risk for medication errors.
Relevant Facts/Findings
Findings included… Record review of Resident 4's Practitioner Orders, dated 01/21/XXXX, Showed Resident 4 received medication twice a day for pain and three times a day for muscle spasms (muscle contracts and cannot relax). Record review of Resident 4's Medication Administration Record, dated 07/01/XXXX, 07/02/XXXX and 07/08/XXXX, showed Resident 4 received both the pain and muscle relaxant medications. There were no staff initials on the medication log to indicate who administered the medications to Resident 1 on those dates. During an interview on 07/11/XXXX at 4:00 p.m., Staff A, Provider, stated that the caregivers were trained and expected to initial the medication log once they administered a medication.
Onsite Correction of Findings Statement
This deficiency was corrected onsite at the time of visit.

b. ICF/IID

Notify the field manager to discuss any deficient practice requiring an immediate plan of correction to protect the health, safety, or welfare of those living in the licensed or certified residential setting.

For federal programs (**NH** and **ICF/IID**), the entity develops a plan of correction, which includes the date the entity asserts they were or will be back in compliance with the regulatory requirement.

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
W426	Rev. 135, Issued: 02-27-15, Effective: 04-27-15, Implementation: 04-27-15) (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
W426	Based on observation and interview, the facility failed to ensure hot water temperatures did not exceed 110 degrees Fahrenheit (F) (unit of measure) in 2 of 3 bathrooms (Bathroom A and Bathroom B) in House Lavender. This failure resulted in elevated hot water temperatures placing clients at risk of injury.
Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
W426	Findings included… Observation on 04/05/XXXX at 10:15 a.m., showed Bathroom A's water temperature, on the facility's thermometer, was 114.7 degrees F. Observation on 04/05/XXXX at 10:32 a.m., showed Bathroom B's water temperature, on the facility's thermometer, was 118.3 degrees F. During an interview on 04/05/XXXX at 10:40 a.m., Staff A, House Manager, reported the water felt hotter today than usual. Staff A stated that they did not check the water temperature in either Bathroom A During an interview on 04/05/XXXX at 3:40 p.m., Staff D, Maintenance Worker, stated that they checked the water system and verified the water heater mixing valve was malfunctioning. Staff D said the valve needed to be replaced.

c. NH

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
F558	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
F558	Based on observation, interview and record review, the facility failed to ensure the height of a closet rod accommodated the need for 1 of 10 residents (Resident 11). This failure placed the resident at risk for the loss of independence.
Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
F558	Findings included… Record review of Resident 11's Minimum Data Set assessment, dated 10/13/XXXX, showed Resident 11 was admitted to the facility on 03/17/XXXX and was cognitively intact. Record review of Resident 11's care plan, dated 04/01/XXXX, showed Resident 11 had limited physical mobility and general muscle weakness. Resident 11's care plan also showed they wanted to be independent and on occasion, required staff to obtain clothing from their closet. Observation on 01/04/XXXX at 9:40 a.m., showed Resident 11 attempted to reach for a sweater in their closet and was unable to extend either of their arms to the height of the clothing rod. During an interview on 01/04/XXXX at 9:41 a.m., Resident 11 stated that they had arthritis that prevented them from reaching high enough to get clothes in or out of their closet. During an interview on 01/09/XXXX at 10:10 a.m., Resident 11 said it was very important they were as independent as possible and disliked having to call for help each time they wanted something from their closet. Resident 11 said they would be "so happy" if the rod in the closet was low enough for them to independently access their clothes.

	During an interview on 01/11/XXXX at 12:41 p.m., Staff U, Nursing Assistant, stated that Resident 11 voiced their concerns about being unable to reach items in their closet. Staff U stated that they told the nurse several times regarding Resident 11's concern. Staff U said they were unaware if anything was done. During an interview on 01/12/XXXX at 8:49 a.m., Staff R, Registered Nurse, said they were told about the difficulty Resident 11 had reaching the clothes in their closet. Staff R stated, "The bar is too high for [Resident 11]." Staff R said they informed the Resident Care Manager and the maintenance staff several times. During an interview on 01/12/XXXX at 9:43 a.m., Staff W, Director of Maintenance, said staff wrote work requests in the maintenance log located at each nurses' station. Staff W reviewed the maintenance logs from August XXXX to January XXXX. Staff W said there was no documentation of a request to readjust Resident 11's closet rod. Staff W said they were unaware of a resident needing their closet rod readjusted until the surveyor inquiry.

3. Principle 5: Interpretive Guidelines – NH and ICF/IID Only

a. ICF/IID

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
W214	§483.440(c)(3)(iii) Identify the client's specific developmental and behavioral management needs; Guidance §483.440(c)(3)(iii) The CFA must address and identify those skill deficits/needed supports that may be amenable to training, those that must be treated by therapy and/or provision of assistive technology, and those that require adapting the environment and/or providing personal support. Assessment of needed supports should be done within the context of the client's age, gender, and culture. "Behavioral management needs" include those behaviors that interfere with progress, prevent assimilation into the community, decrease freedom or increase the need for restriction of activities (e.g. spitting, pica, self-injurious behavior, aggressive behavior toward others or self-injurious behavior). A functional behavioral assessment is a problem-solving process for evaluating client inappropriate behavior. It relies on a variety of techniques and strategies to identify the purpose of the specific behavior(s) and to help the Interdisciplinary Team (IDT) select interventions to directly address the behavior(s). A functional behavior assessment looks beyond the behavior itself. The focus when conducting a functional behavioral assessment is on identifying significant client-specific social, affective, cognitive, and/or environmental factors associated with the occurrence (and non- occurrence) of specific behaviors. The CFA must identify the specific accommodations that address the client's needs to ensure better opportunity for the client's success. The identified accommodations may be assistive technology which can help a person learn, play, complete tasks, get around, communicate, hear, or see better, control their own environment, and take care of their personal needs (e.g. door levers instead of knobs, plate switches, audio books, etc.). This STANDARD is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
W214	Based on observation, interview and record review, the facility failed to assess behavioral management needs for 1 of 8 sampled clients (Client 7). This failure

	resulted in Client 7 not having a training plan for completing tasks and following instructions.
Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
W214	Findings included… Observation on 09/10/XXXX at 2:15 p.m., in the Sound and Light Sensory room showed Client 7 did not provide eye contact or recognition when Staff A, Adult Training Specialist (ATS), cued them. Observation on 09/11/XXXX at 9:20 a.m., in the 307 House, showed Client 7 sat on the floor looking through a pile of magazines. Different staff made several attempts requesting Client 7 to stand up from off the floor. Client 7 did not provide eye contact or recognition to any of the staff. Observation on 09/12/XXXX at 1:00 p.m., in the Sound and Light Sensory room, showed Client 7 sat in a chair in the corner. When the ATS staff provided verbal cues, Client 7 did not provide eye contact or follow the cues. Record review of Client 7's Individual Habilitation Plan (IHP) and Comprehensive Functional Assessment (CFA), dated 12/07/XXXX, showed no documented guidance or instructions on how to successfully engage Client 7 in a group activity or follow cues. During an interview on 09/13/XXXX at 10:00 a.m., Staff P, Qualified Intellectual Disability Professional, stated that it was difficult to encourage Client 7 to engage in group activities. Staff P reviewed and stated that the CFA and the IHP showing Client 7's behaviors of not listening to staff or engaging in group activities were not documented.

b. NH

No example available. Refer to ICF/IID example for reference.

4. Principle 6: Citation of State or Local Code Violations – NH and ICF/IID Only

The entity's failure to comply with State or local laws or regulations is only documented on the CMS-2567 form when the Federal regulation requires compliance with State or local laws.

5. Principle 7: Cross-References

a. AFH

Regulatory Reference
WAC 388-76-10146 Qualifications—Training and home care aide certification. Training and home care aide certification. (6) The adult family home must ensure that all staff receives the orientation and training necessary to perform their job duties. **The requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the entity failed to provide orientation and transfer training for 1 of 3 staff members (Staff B). This failure placed residents at risk for receiving care from untrained staff.
Relevant Facts/Findings
Findings included… Record review of Staff B's, Caregiver, personnel file on 11/15/XXXX, showed the skill and orientation competency checklists were blank. During an interview on 11/15/XXXX at 9:42 a.m., Staff B stated that since their hire date of 09/01/XXXX, they have not received orientation or specific training for their job tasks and duties. During an interview on 11/15/XXXX at 10:25 a.m., Staff A, Provider, stated that Staff B's orientation and skills training was not completed.
Cross Referenced WAC
Refer to WAC 388-76-10400 Care and Services.
Regulatory Reference
WAC 388-76-10400 Care and Services The adult family home must ensure each resident receives: (3) The care and services in a manner and in an environment that: (b) Actively supports the safety of each resident; and **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the entity failed to provide trained staff to assist with transferring 1 of 3 residents (Resident 2) from their bed to their wheelchair. This failure caused harm to Resident 2 when they fell during the transfer.

Relevant Facts/Findings
Findings included… Record review of Resident 2's medical records, dated 11/15/XXXX, showed Resident 2 sustained a left sided hip fracture when they fell while being transferred. Record review of the entity's complaint investigation, dated 11/15/XXXX, showed Staff B used their hands to assist in transferring Resident 2 from their bed to their wheelchair. Resident 2 became unstable on their feet and fell to the floor. During an interview on 11/15/XXXX at 9:42 a.m., Staff B, stated that they tried to transfer Resident 2 from their bed to their wheelchair and wasn't sure how to do this. During an interview on 11/15/XXXX at 10:25 a.m., Staff A, Provider, stated that they did not have documentation that showed Staff B was trained on Resident transfers.

b. ALF

Regulatory Reference
WAC 388-78A-2600 Policies and procedures (2) The assisted living facility must develop, implement, and train staff persons on policies and procedures to address what staff persons must do: (j) To appropriately respond to aggressive or assaultive residents, including, but not limited to: (ii) Actions to take to protect other residents; and (iii) When and how to seek outside intervention. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to implement their policy on protecting residents from verbal abuse for 1 of 3 residents (Resident 1). This failure resulted in Resident 1 being emotionally harmed.
Relevant Facts/Findings
Findings included… Record review of the facility's policy titled, "Aggressive and Assaultive Behaviors", dated 06/XXXX, showed staff were instructed to diffuse a situation by redirecting residents to food or objects. The policy did not identify actions staff would take to protect residents from other residents' aggressive behavior. During an interview on 03/12/XXXX at 10:03 AM, Resident 1 stated that Resident 4 regularly verbally abused them. Resident 1 said Resident 4 called them hurtful names and used foul language. Resident 1 said they reported the abuse to management several times and nothing was done to stop the abuse.

During an interview on 03/12/XXX at 1:33 PM, Staff A, Executive Director, stated that they were aware Resident 4 was verbally abusive toward Resident 1. Staff A stated that this was the only policy they had on responding to aggressive behavior.

Cross Referenced WAC

Refer to Washington Administrative Code 388-78A-2660

Regulatory Reference

WAC 388-78A-2660 Resident rights.
The assisted living facility must:

(1) Comply with chapter 70.129 RCW, Long-term care resident rights;:
(2) Ensure all staff persons provide care and services to each resident consistent with chapter 70.129;
(4) Promote and protect the residents' exercise of all rights granted under chapter 70.129 RCW;

This requirement was not met as evidenced by:

Deficient Practice Statement

Based on interview and record review, the facility failed to promote and protect the rights of 1 of 3 residents (Resident 1) when Resident 4 was verbally abusive toward them. This failure resulted in Resident 1 being emotionally harmed.

Relevant Facts/Findings

Findings included…

Record review of the facility's policy titled, "Resident Rights", dated 06/XXXX, showed Residents had the right to be free from abuse.

During an interview on 03/12/XXXX at 10:03 AM, Resident 1 stated that Resident 4 regularly verbally abused them. Resident 1 said Resident 4 called them hurtful names and used foul language. Resident 1 said they reported the abuse to management several times and nothing was done to stop the abuse.

Observation on 03/12/XXXX at 10:05 AM, showed Resident 1 sat in their chair, was visibly shaking, and had tears in their eyes when they described the verbal abuse.

During an interview on 03/12/XXXX at 1:05 PM, Staff B, Resident Care Coordinator, stated that Resident 4 was verbally abusive to residents. Staff B stated that there were no interventions in place to protect residents from Resident 4's behavior.

During an interview on 03/12/XXX at 1:33 PM, Staff A, Executive Director, stated that they were aware Resident 4 was verbally abusive toward Resident 1. Staff A stated that they did not have documentation of instructions for staff interventions, or how the facility protected Resident 1 from abuse.

c. CCRSS

Regulatory Reference
WAC 388-101D-0125 Client rights. Clients have the same legal rights and responsibilities guaranteed to all other individuals by the United States Constitution, federal and state law unless limited through legal processes. Service providers must promote and protect all of the following client rights, including but not limited to: (5) The right to be free from harm, including unnecessary physical restraint, isolation, excessive medication, abuse, neglect, abandonment, and financial exploitation; **The requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the Provider failed to ensure 1 of 4 sampled clients (Client 1) received staff supervision while in the kitchen. This failure resulted in Client 1 developing hand blisters from the hot water. This caused harm to Client 1.
Relevant Facts/Findings
Findings included… Record review of Client 1's Person Centered Support Plan, dated 06/07/XXXX, showed Client 1 required supervision at all times to avoid health and safety hazards. Record review of the Incident Report (IR), dated 01/10/XXXX, showed Staff A, Program Manager, found Client 1 in the kitchen with their left hand under the hot water of the sink's faucet. Staff A documented the left hand was red in color with white discolored skin. The IR showed Client 1 was taken to an emergency room and treated for second degree burns (damage to the first and second layers of the skin with blisters) to the left hand. The IR showed there was only one staff in the home who was assisting another client. During an interview on 01/15/XXXX at 10:00 a.m., Staff A stated that Staff C, Direct Support Professional, left the home to do a personal errand.
Cross Referenced WAC
Refer to WAC 388-101D-0170 Physical and safety requirements.
Regulatory Reference
WAC 388-101D-0170 Physical and safety requirements (3) The service provider must assist clients in regulating household water temperature unless otherwise specified in the client's individual support plan as follows: (a) Maintain water temperature in the household no higher than one hundred-and twenty-degrees Fahrenheit; **This requirement was not met as evidenced by:**

Deficient Practice Statement
Based on observation, interview and record review, the Provider failed to maintain water temperature at no higher than 120 degrees Fahrenheit (F) (a unit of measure) for 2 of 2 sinks (Sinks 1 and 2). This failure caused harm to Client 1.
Relevant Facts/Findings
Findings included… Record review of the Incident Report (IR), dated 01/10/XXXX, showed Staff A, Program Manager, found Client 1 in the kitchen with their left hand under the hot water of Sink 1's faucet. Staff A documented the left hand was red in color with white discolored skin. The IR showed Client 1 was taken to an emergency room and treated for second degree burns (damage to the first and second layers of the skin with blisters) to the left hand. Record review of the home's Monthly Safety Checklists, dated 11/01/XXXX, 12/01/XXXX, and 01/1/XXXX, showed required water temperature checks were not documented as completed for the months of November, December or January. Observation on 01/15/XXXX at 9:15 a.m., Staff B, Team Leader, tested the water temperature of Sinks 1 and 2. The thermometer showed the water temperature for both sinks was at 130 degrees F. During an interview on 01/15/XXXX at 10:00 a.m., Staff A, Program Manager, stated that they were unaware both sinks' hot water temperatures were at 130 degrees F. They stated that Staff B was responsible to complete hot water checks monthly as part of the home's Monthly Safety Checklist.

d. ESF

Regulatory Reference
WAC 388-107-0160 Behavioral support plan. The enhanced services facility must ensure that each resident's person-centered service plan has interventions for behavioral support that are used immediately when a resident's behavior escalates in the ESF or community. The behavioral support plan must include, at the minimum the following: (2) Specific indicators that may signal a potential crisis for the resident or led to a behavioral crisis in the past, which may include the resident's typical challenging behavior he or she displays during escalation, the resident's typical actions before a behavioral outburst, and words or phrases that the resident has used in the past during escalation; (3) Specific interventions and precrisis prevention strategies for each of the indicators identified above; **The requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to provide a prevention intervention plan as part of the Person-Centered Service Care Plan (PCSP) for 1 of 1 resident (Resident 1). This failure resulted in harm to Resident 1.
Relevant Facts/Findings
Findings included… Record review of the facility's Incident Report dated 07/10/XXXX showed Resident 1 paced and yelled threats toward staff and residents. Resident 1 ran at Staff A, Home Health Aide. Staff A raised their arms and block the attack. Resident 1 fell to the ground and hit their head and nose, causing a nosebleed. Record review of Resident 1's PCSP's, dated 02/27/XXXX, showed they were diagnosed with Intermittent Explosive Disorder (frequent episodes of impulsive anger) and Impulse Control Disorder (difficulty controlling actions or reactions). Resident 1's PCSP showed they had a history of verbal and physical aggression. Resident 1's PCSP section titled "Planned Interventions" was blank. During an interview on 7/22/XXXX with Staff C, Administrator, stated that Resident 1's PCSP prevention intervention plan was incomplete.
Cross Referenced WAC
Refer to WAC 388-107-0190 Rights of Residents

Regulatory Reference
WAC 388-107-0190 Rights of residents. (4) Every resident of an enhanced services facility has the right to appropriate care and individualized treatment, interventions, and support that will not harm the resident. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to provide precrisis interventions to support 1 of 1 residents (Resident 1) when they had a mental health (encompasses emotional, psychological, and social wellbeing) crisis. This failure resulted in harm to Resident 1.
Relevant Facts/Findings
Findings included… Record review of the facility's Incident Report dated 07/10/XXXX showed Resident 1 paced and yelled threats toward staff and residents. Resident 1 ran at Staff A, Home Health Aide. Staff A raised their arms and block the attack. Resident 1 fell to the ground and hit their head and nose, causing a nosebleed. During an interview on 07/22/XXXX at 10:06 AM, Resident 1, stated that their nose and head hurt for several days after they fell. During an interview on 7/22/XXXX at 10:48 AM, Staff C, Administrator, stated that staff were expected to intervene without causing harm.

e. ICF/IID

No example available. Refer to NH examples for reference.

f. NH

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
F657	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be— i. Developed within 7 days after completion of the comprehensive assessment. ii. Prepared by an interdisciplinary team, that includes but is not limited to-- A. The attending physician. B. A registered nurse with responsibility for the resident C. A nurse aide with responsibility for the resident. D. A member of food and nutrition services staff. E. To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. F. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. iii. Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:
Deficient Practice Statement	
Tag	**Summary Statement of Deficiencies**
F657	Based on observation, interview, and record review, the facility failed to initiate a pain management care plan for 1 of 3 residents (Resident 38). This failure placed the resident at risk for unmet pain control needs.

Relevant Facts/Findings	
Tag	**Summary Statement of Deficiencies**
F657	Findings included… During an interview on 04/11/XXXX at 11:22 a.m., Resident 38 stated, "I have pain in my back from a fall several years ago. I take pain medication which takes the edge off. Truly, I am in constant pain." Record review of Resident 38's pain assessment, dated 02/19/XXXX, showed non-medication interventions as: offer a warm blanket, provide one to one care, offer assistance with repositioning and offer activities. Record review of Resident 38's medical record on 04/17/XXXX, showed there was no care plan for pain management. During an interview on 04/17/XXXX, at 2:14 p.m., Staff L, Certified Nursing Assistant, stated that they would review a resident's care plan to know how to care for them. During an interview on 04/18/XXXX at 9:20 a.m., Staff H, Director of Nursing Services, said there were care plans for resident's medical concerns. Staff H reviewed Resident 38's medical record and said the resident did not have a care plan for pain management.
	Cross Referenced F-tag
	Refer to F697 Pain Management.
	Regulatory Reference
Tag	**Summary Statement of Deficiencies**
F697	Pain Management CFR(s): 483.25(k) The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
	Deficient Practice Statement
Tag	**Summary Statement of Deficiencies**
	Based on interview, observation and record review, the facility failed to initiate non-medication related interventions prior to the administration of pain medication for 1 of 4 sampled residents (Resident 38). This failure placed the resident at risk for a lack of non-medication interventions to relieve ongoing pain.
	Relevant Facts/Findings
Tag	**Summary Statement of Deficiencies**
	Findings included…

	Resident 38 was admitted to the facility on 02/15/XXXX with diagnoses to include history of falling, difficulty in walking, and muscle weakness. On 04/11/XXXX at 11:22 a.m., Resident 38 stated, "I have pain in my back from a fall several years ago. I take pain medication, which takes the edge off. Truly, I am in constant pain." On 04/13/XXXX at 12:55 p.m., Resident 38 was asked if staff offered non-medication related interventions for the pain. The resident stated, "Nope. They offer warm blankets if I'm cold but not for pain in my back." Resident 38's pain assessment, dated 02/19/XXXX, showed the following non-pharmacological interventions: offer a warm blanket, provide one to one care, offer assistance with repositioning and offer activities. Review of Resident 38's Medication Administration Record (MAR), from 02/19/XXXX through 04/13/XXXX, showed no documentation of attempted non-pharmacological interventions for pain management. On 04/17/XXXX, at 2:32 p.m., when asked what non-pharmacological pain interventions where in place to manage Resident 38's pain, Staff V said other than pain medication, she wasn't aware of any additional interventions. On 04/18/XXXX at 9:20 a.m., Staff H, Director of Nursing Services, stated non-pharmacological pain interventions were documented on the MAR. Staff H reviewed Resident 38's MAR for the months of March and April XXXX, and said there were no non-pharmacological pain interventions documented on the MAR.

6. Principle 8: Conditions of Participation (COP) Deficiencies – ICF/IID Only

Regulatory Reference	
Tag	**Summary Statement of Deficiencies**
W102	§483.410 Condition of participation: Governing body and management
	Deficient Practice Statement
Tag	**Summary Statement of Deficiencies**
W102	Based on observation, interview and record review facility failed to implement the Condition of Participation for Active Treatment for 6 of 6 sampled clients (Clients 1, 2, 3, 4, 5, & 6) and the Condition of Health Care Services for 2 of 6 sampled clients (Clients 2 & 6). These failures resulted in a lack of training clients to improve their independence.
	Relevant Facts/Findings
Tag	**Summary Statement of Deficiencies**
W102	Findings included… Clients 1, 2, 3, 4, 5, and 6 did not receive active treatment services. Clients 2 and 6 did not receive health care services to meet or improve their health needs. This resulted in not meeting the Condition of Participation for Health Care Services. Refer to W318.

7. Principle 9: Citations with More Than One Regulatory Reference

a. AFH

Regulatory Reference
WAC 388-76-10455 Medication—Administration. For residents assessed with requiring the administration of medications, the adult family home must ensure medication administration is: (1) Performed by a practitioner as defined in chapter 69.41 RCW; or (2) By nurse delegation per WAC 246-840-910 through 246-840-970; **WAC 246-840-930 Criteria for delegation.** (10): If the registered nurse delegator determines delegation is appropriate, the nurse (b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter 7.70 RCW. (18): The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the provider failed to obtain written consent for delegation of medication administration and failed to ensure the delegated staff was observed by a medical professional as required for 1 of 1 resident (Resident 1). This failure placed Resident 1 at risk of receiving services they did not consent to and receiving unsafe administration of medications.
Relevant Facts/Findings
Findings included… Record review of Resident 1's Consent form, dated 02/19/XXXX, showed no signature or date. Record review of Resident 1's Nurse Delegation form, dated 02/28/XXXX, showed Resident 1's last assessment and delegated staff's observation of care by a medical professional was 160 days ago. During an Interview on 04/30/XXXX at 9:34 AM, Staff A, Provider, stated that they did not know Resident 1's consent form was unsigned and undated. Staff A stated that they were also not aware Resident 1's reassessment and delegation staff observation were overdue.

b. ALF

Regulatory Reference
WAC 388-78A-2474 Training and home care aide certification requirements. (2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter 388-112A WAC, including but not limited to: (e) Continuing education. **WAC 388-112A-0611** Who in an assisted living facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed? (1) The continuing education training requirements that apply to certain individuals working in assisted living facilities are described below. (d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete and provide documentation of twelve hours of continuing education within forty-five calendar days of being hired by the assisted living facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to track 12 hours of continuing education (CE) for 1 of 4 caregivers (Staff B). This resulted in residents receiving care from an unqualified caregiver.
Relevant Facts/Findings
Findings included… Record review of Staff B's personnel file on 11/20/XXXX, showed a birth date of 06/10/XXXX, a hire date of 09/07/XXXX, and two hours of CE hours completed between 06/10/XXXX and 06/10/XXXX. During an interview on 11/20/XXXX, at 5:00 p.m., Staff E, Administrator, stated that the facility had computer system problems preventing Staff B from completing the required 12 CE hours. Staff E stated that Staff B did not complete the required 12 CE hours. This was a recurring citation from the previous three inspections dated 09/13/XXXX, 06/11/XXXX and 05/11/XXXX.

c. CCRSS

Regulatory Reference
WAC 388-101-3020 Compliance. The service provider must be in compliance with: (5) Other relevant federal, state and local laws, requirements, and ordinances. **WAC 388-823-1095 What are a person's rights as a DDA client or eligible person?** (5) The client has the right to exercise autonomy and choice free from provider interference. This includes the client's right to: (l) Choose the clothes and hairstyle the client wears; **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on observation, interview, and record review, the provider failed to allow 1 of 4 clients (Client 1) freedom to choose and wear their preferred style of dress and appearance. This failure prevented Client 1 from expressing themselves with their own choice of clothing and hairstyle and caused emotional distress.
Relevant Facts/Findings
Findings included… Record review of the provider's policy titled, "Treatment of Clients", dated 02/28/XXXX, showed staff were instructed to treat all clients with dignity, respecting their human rights and personal preferences. Record review of Client 1's Person Centered Service Plan, dated 11/23/XXXX, showed they were described as able to make decisions about their daily life with some verbal encouragement from caregivers. During an interview on 04/27/XXXX at 12:45 p.m. with Client 1 they stated that they would like to use nail polish, let their hair grow longer, and wear more skirts and heeled shoes. Client 1 stated, "staff don't want me to wear these clothes because my family doesn't like it and it makes me sad". Client 1 stated that they wanted longer hair and did not feel comfortable wearing the clothes their family asked them to wear. Observation on 04/27/XXXX at 12:50 p.m. of Client 1 in their home environment found they had a short haircut and wore jeans, boots, and a button-up shirt. Client 1 showed department staff a selection of skirts and heeled shoes in their closet. During an interview on 04/27/XXXX at 01:22 p.m. with Staff A, House Manager, stated that they were aware of Client 1's preferences but felt it was important that they respect the wishes of their family member to maintain a strong relationship. Staff A stated Client 1 was able to wear their preferred clothing when in their bedroom.

During an interview on 04/28/XXXX at 11:10 a.m. with Staff B, Administrator, they stated that they were aware of Client 1's preference but had decided to respect their family's request.

d. ESF

Regulatory Reference
WAC 388-107-0630 Training and home care aide certification requirements. (2) Continuing education requirements are outlined in chapter 388-112A WAC; registered nurses and licensed practical nurses are exempt from the long-term care worker continuing education requirement. **WAC 388-112A-0612 Who in an enhanced services facility is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?** (1) The continuing education training requirements that apply to certain individuals working in enhanced services facilities are described below. (d) If exempt from certification under RCW 18.88B.041, a long-term care worker must complete 12 hours of continuing education within 45 calendar days of being hired by the enhanced services facility or by the long-term care worker's birthday in the calendar year hired, whichever is later; **The requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to track 12 hours of continuing education (CE) for 1 of 4 home care aides (Staff B). This resulted in residents receiving care from an unqualified caregiver.
Relevant Facts/Findings
Findings included… Record review of Staff B's, Home Health Aide, Personnel File on 11/20/XXXX, showed a birth date of 06/10/XXXX, a hire date of 09/07/XXXX, and no CE hours completed between 06/10/XXXX and 11/20/XXXX. During an interview on 11/20/XXXX at 5:00 p.m., Staff E, Administrator, stated that the facility had computer system problems preventing Staff B from completing the required 12 CE hours electronically. Staff E stated that they had not arranged an alternative method to provide CE hours to Staff B.

8. Principle 10: Components of a Consultation

a. AFH

Consultation Example
WAC 388-76-10320 Resident Records-Content. The adult family home must ensure that each resident record contains, at a minimum, the following information: (10) A current inventory of the resident's personal belongings dated and signed by: (a) The resident; and (b) The adult family home. The home did not maintain a current inventory list when Resident 2's family brought them new clothing items. Resident 2 and their family stated that no items were currently missing, and they would appreciate having an inventory record.
Onsite Correction of Findings Statement
This deficiency was corrected onsite at the time of visit.

b. ALF

Consultation Example
WAC 388-78A-2620 Pets. If an assisted living facility allows pets to live on the premises, the assisted living facility must: (1) Ensure animals living on the assisted living facility premises: (a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington State; The community pet's (Pet 1) rabies vaccine expired on 04/13/XXXX, three months earlier. The ALF scheduled and transported Pet 1 to a same-day veterinarian appointment to receive the rabies vaccine.
Onsite Correction of Findings Statement
This deficiency was corrected onsite at the time of visit.

c. ESF

Consultation Example
WAC 388-107-0100 Person-centered service planning team. The enhanced services facility must develop and maintain a person-centered service planning team for each resident. The ESF must: (1) Ensure the person-centered service planning team includes the resident, the resident's representative when applicable, individuals chosen by the resident, a mental health professional, nursing staff, the Medicaid client's Department case manager, and other persons as needed; (2) Provide the necessary information and support to ensure that the resident has an opportunity to identify team members, make informed choices and decisions regarding care and treatment, and direct the person-centered service planning process as much as possible; (3) Ensure the person-centered service planning team has a coordinated approach to the development, implementation, and evaluation of the comprehensive person-centered service plan for the resident; and (4) Ensure the person-centered service planning team meets at least monthly and more often as needed, at times and locations convenient to the resident, to review and modify the comprehensive person- centered service plan as needed. The ESF had not developed, implemented, or evaluated an organized Person-Centered Service Planning Team process to meet the needs of each of the residents. This failure has the potential to result in unmet care and service needs for each resident.
Onsite Correction of Findings Statement
This deficiency was corrected onsite at the time of visit.

8. Principle 11: Recurring/Repeated, Uncorrected, and/or Previously Cited

a. AFH

Regulatory Reference
WAC 388-76-10485 Medication storage. The adult family home must ensure all prescribed and over-the-counter medications are stored: (1) In locked storage; (a) (3) Appropriately for each medication, such as if refrigeration is required for a medication and the medication is kept in refrigerator in locked storage. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on observation and interview, the entity failed to provide locked storage for liquid antibiotic medication stored inside the kitchen refrigerator for 1 of 4 residents' (Resident 1). This failure placed residents at risk for accidental medication ingestion.
Relevant Facts/Findings
Findings included… Observation on 08/10/XXXX at 10:00 AM showed a bottle of liquid medication used to treat infections was in the kitchen refrigerator. The bottle was labeled as belonging to Resident 1 and was placed on a shelf among bottled beverages. During an interview on 08/10/XXXX at 11:00 AM Staff A, Provider, stated that they were unaware the liquid medication was not in a locking box in the refrigerator. This is an uncorrected deficiency previously cited on 06/30/XXXX

b. ALF

Regulatory Reference
WAC 388-78A-2450 Staff. (2) The assisted living facility must: (b) Verify staff persons' work references prior to hiring; (3) The assisted living must: (d) maintain the following documentation of the assisted living premises, during employment, and at least two years following termination of employment: (A) Training required by chapter 388-112A WAC; (iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section. **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on record review and interview, the facility failed to verify and maintain reference check documentation for 4 of 8 sampled staff members (Staff B, D, E, & G) in each of their personnel files. This failure placed residents at risk of receiving care from unqualified staff members.
Relevant Facts/Findings
Findings included… Record review of the facility's hiring policy titled, "Steps to Hiring Quality Staff", dated June XXXX, showed staff reference checks were to be completed prior to hire. A copy of the reference checks were to be maintained in each of the staff member's personnel file. Record review of Staff B, D, E, and G's personnel files on 03/25/XXXX, showed: • Staff B, Caregiver, was hired on 08/15/XXXX and contained three blank reference check forms; • Staff D, Caregiver, was hired on 08/24/XXXX and contained three blank reference check forms; • Staff E, Licensed Nurse, was hired on 07/02/XXXX and contained one blank reference check form; • Staff G, Caregiver, was hired on 07/06/XXXX and contained no reference check forms. During an interview on 03/25/XXXX at 4:00 p.m., Staff A, Administrator, stated that the reference check forms for Staff B, D, E were not completed. Staff A stated that they were unable to locate the reference check form for Staff G. This is an uncorrected deficiency previously cited on 02/15/XXXX.

c. CCRSS

Regulatory Reference
388-101D-0170 Physical and safety requirements. (3) The service provider must assist clients in regulating household water temperature unless otherwise specified in the client's individual support plan as follows: (a) Maintain water temperature in the household no higher than one hundred and twenty degrees Fahrenheit; **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on observation, interview, and record review, provider failed to ensure safe water temperatures for 2 of 3 sampled water faucets (Faucet 1 and Faucet 2). This failure resulted in water temperature exceeding 120 degrees Fahrenheit (F) and placed the client at potential risk of burns.
Relevant Facts/Findings
Findings included… Record review of the provider's Plan of Correction for this same regulatory reference, submitted to the department on 07/06/XXXX, showed they would check all water temperatures daily and document thermometer readings in the Safety Binder. Record review of Client 1's Person Centered Service Plan, dated effective on 01/18/XXXX showed they needed full physical assistance to avoid health and safety hazards. Observation on 08/21/XXXX, at 8:12 a.m. during a tour at Client 1's home, showed the hot water temperature at Faucet 1, the bathroom sink, was taken with a digital thermometer and read 122.7 degrees F. Observation on 08/21/XXXX at 8:30 a.m., hot water temperature taken at Faucet 2, the kitchen sink, read 123.4 degrees F on the digital thermometer. Hot steam was visible at Faucet 2 from the running water during the water temperature reading. Interview on 09/01/XXXX at 08:40 a.m. with Staff B, Care Manager, found they had requested the home's staff check water temperatures daily, but could not locate documentation that had occurred. This is an uncorrected deficiency previously cited on 06/31/XXXX.

d. ESF

Regulatory Reference
WAC 388-107-0370 Treatment services. The enhanced services facility must: (1) Provide for diagnostic and therapeutic services prescribed by the attending clinical staff that meet all of the resident needs identified in the person-centered service plan, to include mental health and chemical dependency treatment **This requirement was not met as evidenced by:**
Deficient Practice Statement
Based on interview and record review, the facility failed to provide mental health services in accordance with Person-Centered Service Plans for 2 of 6 sampled residents (Residents 3 & 5). This failure placed residents at risk of not having their mental health needs met.
Relevant Facts/Findings
Findings included… <Resident 3> Record review of Resident 3's admission paperwork, dated 08/11/XXXX, showed they were admitted on 08/11/XXXX with multiple mental health diagnoses and mood disorders. Record review of Resident 3's Person-Centered Service Plan (PCSP), dated 08/11/XXXX, showed Resident 3 was to receive mental health services from a qualified provider three times a week. During an interview on 10/19/XXXX at 11:26 a.m., Resident 3 stated that they had not seen a mental health provider (MHP) since admission to the facility. Record review of Resident 3's Care Notes, dated 10/19/XXXX, showed no documentation of a MHP visit. <Resident 5> Record review of Resident 5's admission paperwork, dated 08/15/XXXX, showed they were admitted on 08/15/XXXX, with multiple mental health diagnoses. Record review of Resident 5's PCSP, dated 08/15/XXXX, showed Resident 5 was to receive mental health services from a qualified provider three times a week. Record review of Resident 5's Care Notes, dated 10/19/XXXX, showed Resident 5 had a scheduled appointment with the MHP on 10/16/XXXX.

During an interview on 10/19/XXXX at 1:56 p.m., Resident 5 stated that they had an appointment to meet an MHP on 10/16/ XXXX, but the MHP did not show up. Resident 5 stated that the MHP did not receive a request for a new appointment date.

During an interview on n 10/19/XXXX at 3:00 p.m., Staff C, Administrator, stated that neither Resident 3 nor Resident 5 have seen an MHP.

This is a recurring deficiency previously cited on 12/01/XXXX and 02/20/XXXX.

C. Glossary of Terms

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

Agency – State agency.

Assisted Living Facility (ALF) – State licensed facilities providing basic services assuming general responsibility for the safety and well-being of vulnerable adults. ALFs allow the vulnerable adults to live an independent lifestyle in a community setting while receiving necessary services from a qualified workforce. ALFs can vary in size and ownership from a family-operated 7-bed facility to a corporation-based facility with 150+ beds. ALFs may provide intermittent nursing services or serve vulnerable adults with mental health needs, developmental disabilities, or dementia.

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

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

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

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

Certification evaluation – A CCRSS regulatory process whereby contracted evaluators assess provider compliance with statutes and regulations. In addition to certification evaluations at least once every 24 months, contracted evaluators may also conduct follow-up visits.

Certified Community Residential Services and Supports (CCRSS) – Includes Supported Living (SL), Group Homes (GH), and Group Training Homes (GTH). These are residential services provided to individuals who are eligible clients of the Developmental Disabilities Administration (DDA). Supported living clients are vulnerable adults living in their own homes in the community. The client or legal representative owns, rents, or leases the home.

Certified Group Home – A community-based licensed and certified residential program where the provider, who contracts with the Department of Social & Health Services (DSHS), DDA to provide residential services, owns, or leases the facility. The majority are privately owned businesses. The homes vary in size, serving from 4 to 10 clients.
Residential Care Services (RCS) licenses the home as either an Assisted Living Facility or an Adult Family Home and certifies the group home through a separate process. This supports the provision of services at the levels required by the DDA contract.

Room and board expenses are included in the rate paid by DDA and the clients participate toward their cost of care. DDA contracts with these providers to provide 24-hour supervision.

Certified supported living services – Residential services provided to DDA clients living in their own homes in the community. DDA contracts with individuals and agencies to provide these services. Clients pay for their own rent, food, and other personal expenses. Supported living

offers instruction and support, which may vary from a few hours per month to 24 hours of one-on-one support per day. DDA pays for residential services provided to clients under Department contract at the contracted rate.

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

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

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

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

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

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

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

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.

Complaint investigation/investigator (CI) – An onsite visit that resulted from a complaint rather than a routine inspection. An RCS staff assigned to investigate a complaint received by the department.

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

- Structure
- Process
- Outcome

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

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

Consultation in ALF – Documentation of a first-time violation of statute or regulation with minimal or no harm to the vulnerable adults residing in the ALF. Consultations are never

written for care and services or safety areas that will impact the vulnerable adults living in the ALF. A Consultation is a violation that does not require an attestation. Consultation in an ALF may also occur if the entity corrects the violation and/or the deficient practice meeting the following criteria:

- Is corrected to the satisfaction of RCS prior to the exit;
- Is not a violation of a statute or regulation that was cited in one of the two most recent preceding regulatory processes; and
- Did not pose a significant risk of harm or actual harm to a vulnerable adult.

Consultation in 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.

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.

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

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

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

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

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

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

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

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.

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.

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

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

Facility – as defined in RCW 74.34.020.

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

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

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

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.

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

Group Training Homes (GTH): A facility which provides 24-hour supervision, full-time care, treatment, and training for two or more adults with developmental disabilities. Operated on a non-profit basis by a person, association, or corporation. Room and board expenses are included in the rate paid by DDA and the clients participate toward their cost of care. Also known as, "Epton Act Homes", the Group Training Home model was created by legislation drafted in the early 1970's.

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

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

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

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

Imminent danger or **Immediate threat** – means serious physical harm to or death of a resident has occurred, or there is a serious threat to the resident's life, health, or safety.
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.
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The Social Security Act created this optional Medicaid benefit to fund "institutions" (four or more beds) for individuals with intellectual disabilities. The Secretary defines this as providing "active treatment."
Last Date of Data Collection (LDDC) – The final date data was collected for the Compliance Determination (CD).
Licensee – A generic term to describe individuals or entities licensed or certified to provide services as an adult family home, assisted living facility, enhanced services facility, and/or nursing home care in the state of Washington.
Likely/likelihood – means the nature and/or extent of the identified noncompliance creates a reasonable expectation that an adverse outcome resulting in serious injury, harm, impairment, or death will occur if not corrected.
Medicaid Fraud Control Division (MFCD) – This statewide division is based in Olympia and includes a branch of four staff in Spokane to focus on Eastern Washington. MFCD investigates and prosecutes the criminal abuse and neglect of vulnerable adults in Medicaid-funded facilities and fraud perpetrated by health care providers against the Medicaid system.
Mental health professional (MHP) – any person qualified and licensed to provide assessments, diagnosis, and therapy for mental health conditions.
Minimal harm – means violations that result in little to no negative outcome or little or no potential harm for a resident.
Minimum Data Set (**MDS)** – a core set of screening, clinical assessment, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid and for patients receiving SNF services in non-critical access hospitals with a swing bed agreement.
Moderate harm – means violations that result in negative outcome and actual or potential harm for a resident.
Noncompliance – means failure to meet one or more federal health, safety, and/or quality regulations.
Nursing facility (NF) – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under section 1919(a) of the federal Social Security Act. All beds in a nursing facility are certified to provide Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.
Nursing home (NH) – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

Opportunity to correct (NH) – means the entity is allowed an opportunity to correct identified deficiencies before remedies are imposed.

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.

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

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

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

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

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

- **State Employees** – are generally DSHS staff who are making a report in the natural course of their job duties.

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.

Scope and severity (S/S) – The effect of the deficient practice on resident outcome (severity level) and the number of residents potentially or actually affected (scope level), using the decision matrix grid guidance provided by CMS (**NH** only).

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.

Skilled nursing facility (SNF) – a nursing home, a portion of a nursing home, or a long-term care wing or unit of a hospital that has been certified to provide nursing services to Medicare recipients under section 1819(a) of the federal Social Security Act.

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

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

Supported living – Certified service providers offer instructions and supports in client homes which may vary from a few hours per month to 24 hours of one-on-one support per day. Clients pay for their own rent, food, and other personal expenses. DDA pays for residential services provided to clients under the Department contract at the contracted rate. DDA may also contract with providers for crisis diversion and community protection services.

Supported living services – Residential services provided to clients living in their own homes in the community, which are owned, rented, or leased by the clients or their legal representatives.

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

Universe – The 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.

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

D. Acronym List

AA	Administrative Assistant
AAG	Assistant Attorney General
ACO	Aspen Central Office
ACTS	ASPEN Complaints/Incidents Tracking System
AFH	Adult Family Homes
ALF	Assisted Living Facilities
ALJ	Administrative Law Judge
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
ASPEN	Automated Survey Processing Environment System
BIC	Back In Compliance
CC	Collateral Contact
CCRSS	Certified Community Residential Services and Supports
CD	Compliance Determination
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COP	Conditions of Participation
CRS	Construction Review Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DAB	Department of Appeals Board
DCAT	Deficiency Citation Analysis Tool
DCYF	Department of Children, Youth, and Families
DDA	Developmental Disabilities Administration
DOH	Department of Health
DOL	Department of Licensing
DOSH	Division of Safety and Health (Labor and Industries)
DPS	Deficient Practice Statement
DRW	Disability Rights Washington
DSHS	Department of Social and Health Services
eCFR	Electronic Code of Federal Regulation
EHR	Electronic Health Record
EMR	Electronic Medical Record
ePOC	Electronic Plan of Correction
ESF	Enhanced Services Facilities
EWP	Electronic Working Papers
FM	Field Manager
FMS	Facility Management System
FSA	Field Services Administrator
HH	Household Members

ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ID	Identification
IDR	Informal Dispute Resolution
IJ	Immediate Jeopardy
LDDC	Last Date of Data Collection
LE	Law Enforcement
L&I	Labor and Industries
LHJ	Local Health Jurisdiction
LHM	Licensee History Memo
LTC	Long-Term Care
LTCSP	Long-Term Care Survey Process
MDS	Minimum Data Set
MFCD	Medicaid Fraud Control Division
MHP	Mental Health Professional
NA	Nurse's Aide/Nurse's Assistant
NF	Nursing Facility
NH	Nursing Homes
OFA	Office of Fraud and Accountability
OSFM	Office of State Fire Marshal
POC	Plan of Correction
POD	Principles of Documentation
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RHC	Residential Habilitation Centers
RIQAP	Residential Inspection and Quality Assurance Program
RN	Registered Nurse
RO	Regional Office
SA	State Agency
SNF	Skilled Nursing Facility
SOB	Shortness of Breath
SOD	Statement of Deficiency
SOM	State Operations Manual
SOP	Standard Operating Procedures
SQC	Substandard Quality of Care
S/S	Scope and Severity
STARS	Secure Tracking and Reporting System
WAC	Washington Administrative Code
WD	Working Day
WHCA	Washington Health Care Authority

E. Change Log

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
08/23/2024	• Part I.A Data Entry Timelines	Clarified use of exit dates and last date of data collection, including visuals	Provide clarified guidance to staff	MB R24-069 Support Call 09/10/2024
08/23/2024	• Part II Principles of Documentation (POD)	Section relocated from Chapter 27 – Principles of Documentation	Align with relevant SOP content, clarify guidance	MB R24-069 Support Call 09/10/2024
08/23/2024	• Part III.A D, E Field Safety	Section relocated to Chapter 21 – Occupational Health and Safety	Align with relevant SOP content	MB R24-069 Support Call 09/10/2024
08/23/2024	• Part III.D & E Request Observation of RCS Activity Constituent Referral and Complaint Process	Sections relocation to Chapter 1 - Administration	Align with relevant SOP content	MB R24-069 Support Call 09/10/2024
08/23/2024	• Part IV.B POD Examples	Examples updated and expanded to cover all relevant programs	Provide guidance for staff	MB R24-069 Support Call 09/10/2024
04/24/2024	• Part I	Statement of Deficiency and Plan of correction processes added (moved from Chapter 7)	Align with relevant SOP content to relate field guidance that extends beyond enforcement	MB R24-036
04/24/2024	• Part I.I. Confidential Identifier Lists	Developed written guidance along with official forms for the creation of confidential identifier lists	Provide clear direction and consistent approach for all staff statewide, across all programs	MB R24-036

Eff. Date	Chapter/ Section #	Description of Change	Reason for Change	Communication and Training Plan
04/24/2024	• Part I.E. Record Retention	Section moved to Chapter 23 – Record Management	Align with relevant SOP content	MB R24-036
07/14/2023	Full Chapter	Updated formatting	To provide easier chapter navigation	MB R23-063
07/14/2023	• Part I.DE Other Regulatory Requirements	Subchapter developed	To provide staff guidance	MB R23-063
07/14/2023	• Part I.EE Record Retention	Subchapter developed	To provide staff guidance	MB R23-063
07/14/2023	• Part I.G. Constituent Referral and Complaint Process	Subchapter developed	To provide staff guidance	MB R23-063
08/13/2019	Full Chapter	Removed the word "Protocol." Deleted blank pages.	Revision to Ch. 20	Ch. 20 MB will encompass all revisions

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