Overview

This Standard Operating Procedure (SOP) chapter contains the process Residential Care Services (RCS) staff must follow when conducting complaint investigations across all programs.

For the purposes of this chapter:

- 'Facility/home/provider' in this document will refer to adult family homes (AFH), nursing homes (NH), assisted living facilities (ALF), certified community residential services and supports (CCRSS), enhanced services facilities (ESF), and intermediate care facilities for individuals with intellectual disabilities (ICF/IID). All settings will be referred to as 'provider' in this chapter.
- 'Vulnerable adult' will refer to residents (all settings except CCRSS) or clients (CCRSS setting only). In this chapter, the term 'resident' will be used for all settings.

These procedures are specific to Residential Care Services and are not covered by DSHS Administrative Policies.

Contacts

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

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Background

RCS has primary investigative responsibility for alleged reports of provider practice violations related to abuse, neglect, exploitation, and abandonment of vulnerable adults in all licensed and/or certified settings regulated by RCS. This standard operating procedure provides consistent practices across all RCS programs.

Each complaint is unique, and the investigation must focus on the areas where RCS has jurisdiction in that specific setting. Regulations and the population served by each care setting vary so all these factors must be considered when developing the required investigative plan.

A complaint investigation is not a full inspection/survey. These investigations are focused solely on the allegations contained in the intake, as well as any concerns discovered during the investigation.
This SOP outlines the expectations for staff conducting complaint investigations:

- How to process and review complaint assignments
- How to prepare for an investigation and develop a plan
- What to do after leaving a provider and making a final determination
- How to write reports and issue them within the required timelines
- How to close a complaint
- How to report complaints from the field

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Part I: Complaint Investigations – All Settings

A. Off-site Preparation & Activities to Prepare for the Investigation

Assignment and Review of the Intake

1. Intake receipt and assignment:
   The Administrative Assistant (AA) or designee will, upon receiving notification of a complaint intake from the Complaint Resolution Unit (CRU), assign it for investigation to the appropriate Complaint Investigator (CI), and include any additional pertinent instructions.
2. Reviewing the intake:
   The CI will review the following information in STARS upon receiving the assigned intake:
   a. The assigned CRU priority assignment.
      Note: Any changes to assigned priority must follow RCS SOP Manual Chapter 4 – Processing Complaint Referrals and Priority Changes.
   b. CRU referrals made at the point of intake to other agencies and services.
   c. Any preliminary issues related to the allegation(s).

Reviewing the Provider and Resident History

The CI will review the following for the alleged victim (AV), alleged perpetrator (AP) and provider:
1. Relevant complaints within the last year, noting any similar issues, AVs, APs, and collateral contacts reported.
2. ASPEN, FMS, STARS and CARE, as applicable.
3. Status of provider, as applicable:
   a. License/certification number and number of residents for which the provider is licensed.
   b. Current state contracts and/or any specialty designations (i.e., memory care, mental health, Developmental Disabilities Administration [DDA]).
   c. Most recent inspection/certification survey findings, noting any uncorrected deficiencies.
   d. Enforcement history including any conditions on the license/certification.
   e. Exemptions.
   f. Recent changes of ownership (CHOW).

   Note: For Unlicensed or Uncertified facilities, please refer to Appendix F.

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Public Complainant (PC) Interview

1. Generally, it is the expectation the CI will make a minimum of three attempts to reach the PC and document attempts (date and time) in the electronic working papers (E-WP) prior to initiating the investigation on-site (See 'Public Complainant (PC) decision tree' for more information).
2. Attempts to reach the PC must be conducted in different parts of the day when possible and spread out over the day or week when permitted by the timeframe of the complaint investigation process.
3. Refer to 'Questions to Consider for the Public Complainant' for sample questions to consider using when interviewing a PC.
4. Exceptions to contacting the PC before investigation initiation:
    a. Examples of appropriate reasons for exception may include the following circumstances:
        - urgency of the intake
        - addition of an intake to an already initiated investigation
        - travel
        - PC resides under the care of the provider
    b. CIs will consult with the Field Manager (FM) about any situations where the PC will not be contacted and document that conversation in the E-WP. Documentation must include the date and time the FM was consulted, and brief description of reasons of why contact was delayed. Refer to 'Public Complainant Contact Documentation' for documentation examples.
5. When interviewing a PC, explain confidentiality will be respected and their name would only be disclosed should a legal hearing occur.
    a. Explain while you will do everything possible to protect their confidentiality, sometimes a provider may recognize the situation or issue being investigated and independently relate this to the PC.

Coordination with Adult Protective Services (APS)

1. Document attempts to coordinate on-site visits with the assigned Adult Protective Services (APS) Investigator when appropriate and possible.
2. APS will not complete an investigation for any allegations except physical or sexual abuse **unless** the CI updates APS that an investigation is needed. Follow the process outlined in Coordination and Communication with APS.

Developing an Investigation Plan

Prior to investigating the investigation on-site, the CI will develop a brief documented investigative plan to include:

1. Regulatory requirements pertinent to the allegation to identify regulations that could potentially be cited.
2. Determine if Law Enforcement (LE) or other investigative entities (APS, Department of Health [DOH], etc.) need to be contacted to coordinate investigative activities prior to conducting any on-site investigation.
3. Identify observations that will be helpful based on the allegation. See section labeled 'Observations' for planning considerations.
4. Develop focused interview questions based on the allegation. See section labeled 'Interviews' for planning considerations.
5. Identify needed record reviews based on the allegation. See section labeled 'Record Reviews' for planning considerations.
6. Plan when on-site initiation should occur.
   Note: Plan the on-site visit so it occurs at the time/day the alleged issue is most likely to occur (e.g., when the AP may be working, when there might be inadequate staffing, etc.).

See Appendix E for examples of plans for specific allegation types (including observations to collect, persons to interview, questions to ask, etc.).

Observations

Observations are the most powerful evidence investigators collect, especially when validated by interviews and record reviews. Prior to initiating observations as part of the investigation, the CI will:

1. Complete a brief tour of the building(s) to become familiar with the layout of resident rooms and common areas if it is their first time visiting a provider.
2. Obtain a copy of the resident census and names of staff on duty, if applicable.
   Note: In an **ICF/IID**, a census is only requested if it is needed for the nature of the complaint.
3. Determine if any individuals need to accompany the CI when conducting observations. For example, a nurse colleague is needed to complete a skin observation within the bikini area.
   a. If a nurse is not available, consult with your FM to determine how to proceed.

When planning observations use critical thinking, and consider the following:

- Location or setting where observations will be completed (i.e., hospital, provider, or other setting).
- Whether observations will be completed in conjunction with other activities (i.e., treatments, mealtimes, etc.)
- Location where the reported incident allegedly occurred.
- Day(s), time(s) or individuals to be observed, including observing specific individuals with residents.

Note: More than one observation may be needed depending on the reported concern.

Interviews

Effective communication is key to the investigation process. The CI must be courteous, respectful, objective, neutral, and able to communicate with PCs, residents, and provider staff in a clear and easily understood manner.

The CI must:

1. Interview all named AVs whenever possible as the primary source of data. This includes AVs who are no longer a resident.
   Note: If there is a need to protect the identity of the AV, consider interviewing other residents not named in the intake.
2. If the AV is deceased, the CI will interview the AV's representative or family. See 'Contacting relatives of a recently deceased AV' for an example of how to initiate that conversation.
3. Make a minimum of three attempts to complete the interview with the named AV(s) or representative(s). All documented attempts must include the date, time and how the attempts were made in the E-WP.
4. If there is a compelling reason to not complete an interview with a named AV, the CI will consult with their FM and clearly document consultation and compelling reasons in the E-WP.

   Note: If the reported concern involves **infection control only** and does not allege any failure on the part of a provider or an individual (i.e., influenza, pneumonia, norovirus, etc.), AV interviews are not needed.

When determining who needs to be interviewed, use critical thinking, and consider the following individuals:

- Alleged victims (AVs)
- Other residents
- Provider's administrative or provider staff
- Veteran's Administration (VA) personnel
- Healthcare staff
- Activity center staff or coordinators
- Long-Term Care (LTC), Developmental Disabilities (DD) and/or Mental Health (MH) ombuds
- Alleged perpetrators (APs)
- Legal representatives or family
- Visitors
- Nurse delegators
- Law Enforcement
- Social clubs
- Other department or agency staff (HCS/DDA/MH/APS case managers)

Note: In a **CCRSS** setting, CIs must conduct an interview with the Administrator or designee(s) as part of the investigation. A minimum of three attempts must be made, with attempts documented in the E-

WP. This interview does not remove the requirement to complete the Outcome Conference with the Administrator.

When interviewing the provider's staff, CIs will conduct the interview during the staff's regular work hours when possible.
Factors that could impact an interview should be considered when planning interviews. Those factors may include:

1. Which interviews should be conducted prior to on-site initiation.
2. Whether interviews should be completed before or after observations.
3. What setting would be best to conduct the interview, focusing on providing optimal comfort and privacy for the individual being interviewed.
4. If any accommodations needed (e.g., interpreter, large print questions, etc.).
5. If there are any additional privacy considerations (e.g., ability to remove monitors, turn off intercoms, etc.).

Record Reviews

Use information gathered through record reviews to validate and/or clarify information already obtained through observation and interview. The CI may need to expand the scope of the requested documents, if needed, to protect the source of information or the PC.

Planned reviews may need to be adjusted based on observations, interviews, and other data obtained on-site. The CI should not spend excessive time gathering and recording information not pertinent to the concern.

Document the resident's legal representative including mailing address, phone number and email address, if applicable, unless already provided in other documents (i.e., data sheets, face sheets, etc.)

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When determining what records will be pertinent to the investigation, consider the following:

- Open and/or closed resident records
- Assessments
- Negotiated care plans (NCPs)
- Person Centered Service Plans (PCSPs)
- Treatment Administration Records (TARs)
- Incident logs
- Hospital records
- Provider policies
- Financial records related to managing vulnerable adults' funds
- Contracts
- Maintenance records
- Admission agreements
- Service Agreements
- Individual Program Plans (IPPs)
- Medication Administration Records (MARs)
- Behavioral monitoring documents
- Progress notes
- Staffing schedules
- Outside provider health agency records (i.e., hospice, home health, therapy services)
- Housekeeping records

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B. Infection Prevention and Control Assessment

Background

The COVID-19 pandemic has highlighted the need for effective Infection Prevention and Control (IPC) in long-term care settings. As a result, IPC assessments will be part of every inspection and complaint investigation. This process provides regulatory staff with tools and guidance to adequately assess community infection prevention and control practices and protocols.

AFH, ALF, and ESF

Procedure

1. The IPC assessment must be initiated during the off-site preparation and entrance to gather data and determine the next steps.
2. IPC Forms. *Further explanation of forms and how to choose which form to use is in Section 3 (below).*
    a. There are two forms to assist with the IPC assessment: The Pathway (DSHS 00-411) provides prompts and details to complete the IPC assessment. The Tool (DSHS 00-412) is a checklist version of the Pathway.
        i. The Pathway **OR** the Tool must be used by regulatory staff for the IPC Assessment.
        ii. Completion of the Pathway or the Tool in its entirety is required for all inspections, evaluations, and IPC complaint investigations.
            - If multiple intakes are investigated during the same field visit, regulatory staff will add a statement to their electronic working papers which directs which file or electronic folder contains the ICP Pathway or Tool.
              Example: "The IPC Pathway is located with working papers for Intake 0000"
    b. For non-IPC complaint investigations regulatory staff will:
        i. Complete standard IPC off-site preparation and entrance activities;
        ii. Document off-site preparation and entrance activities in the E-WP **OR** on the IPC form;
        iii. Complete the Pathway or the Tool if an IPC issue is discovered during complaint investigation; and
        iv. Bring an IPC form when going into any setting for all complaint investigations, in the event an IPC concern is discovered. Consult with Field Manager if concerns are identified.
    c. The IPC forms will not be used for non-IPC monitoring or follow-up or revisits.

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3. IPC Forms Explained:
   The Pathway and the Tool are forms designed to guide regulatory staff to assess elements through observations, interviews, and record reviews required to complete the IPC assessment. The specific form to use depends on the knowledge, experience, and understanding of the process of each regulatory staff. If unsure of which form to use, staff will consult with the Field Manager. The IPC Notes form is used if more space is required for additional documentation or notation.
   a. IPC Pathway: (DSHS 00-411)
      i. The Pathway provides expanded instructions based on the COVID Response Plan for Long Term Care Recommendations and Requirements, which includes Centers for Disease Control and Prevention, Department of Health, and Local Health Jurisdiction guidance.
      ii. The Pathway offers more detailed instructions for the IPC Assessment.
   b. IPC Tool: (DSHS 00-412)
      i. The Tool has a checklist on the front of the page with condensed instructions and a notes section on the back page for documentation.
      ii. The Tool offers less detailed instructions for the IPC Assessment.
   c. IPC Notes: (DSHS 00-412A)
      i. The Notes form is not meant to replace the Pathway or the Tool. It is designed as a supplement when additional documentation is needed.
      ii. The Pathway and the Tool are organized by sections with corresponding letters for easy documentation reference on the Notes form.

Regulatory staff will document IPC observations, interviews, and record reviews on the IPC forms and submit the forms with the E-WP.

The forms will be updated as the LTC COVID Response Plan is updated.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:
1. Train new staff and ensure they can demonstrate they understand this procedure.
2. Conduct periodic reviews of this procedure to ensure staff are following it correctly.
3. Request training or clarification from headquarters as needed.

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CCRSS

Procedure

1. The IPC off-site preparation and entrance activities must be done to gather data and determine the next steps.
2. IPC Forms. *Further explanation of forms and how to choose which form to use is in Section 3 (below).*
   a. There are two forms to assist with the IPC assessment: The CCRSS Pathway (DSHS 00-410) provides prompts and details to complete the IPC assessment. The CCRSS Tool (DSHS 00-413) is a checklist version of the Pathway.
      i. The Pathway **OR** the Tool must be used by regulatory staff for the IPC Assessment.
      ii. Completion of the Pathway or the Tool in its entirety is required for all evaluations and IPC complaint investigations.
         - If multiple intakes are investigated during the same field visit, regulatory staff will add a statement to their electronic working papers which directs which file or electronic folder contains the ICP Pathway or Tool.
           Example: "The IPC Pathway is located with working papers for Intake 0000"
   b. For non-IPC complaint investigations regulatory staff will:
      i. Complete standard IPC off-site preparation and entrance activities;
      ii. Document off-site preparation and entrance activities in the E-WP **OR** on the IPC form;
      iii. Complete the Pathway ***OR*** the Tool if an IPC issue is discovered during complaint investigation; and
      iv. Bring an IPC form when going into any setting for all complaint investigations, in the event an IPC concern is discovered. Consult with the FM if concerns are identified.
   c. The IPC forms will not be used for non-IPC monitoring or follow-up or revisits.
3. IPC Forms Explained:
   The Pathway and the Tool are forms designed to guide regulatory staff to assess elements through observations, interviews, and record reviews required to complete the IPC assessment. The specific form to use depends on the knowledge, experience, and understanding of the process of each regulatory staff. If unsure of which form to use, staff will consult with the FM. The IPC Notes form is used if more space is required for additional documentation or notation.
   a. IPC Pathway: (DSHS 00-410)
      i. The Pathway provides expanded instructions based on the COVID Response Plan for Long Term Care Recommendations and Requirements, which includes Centers for Disease Control and Prevention, Department of Health, and Local Health Jurisdiction guidance.
      ii. The Pathway offers more detailed instructions for the IPC Assessment.

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b. IPC Tool: (DSHS 00-413)
   i. The Tool has a checklist on the front of the page with condensed instructions and a notes section on the back page for documentation.
   ii. The Tool offers less detailed instructions for the IPC Assessment.
c. IPC Notes: (DSHS 00-413A)
   i. The Notes form is not meant to replace the Tool or the Pathway. It is designed as a supplement when additional documentation is needed.
   ii. The Tool and the Pathway are organized by sections with corresponding letters for easy documentation reference on the Notes form.

The CI will document IPC observations, interviews, and record reviews on the IPC forms and submit the forms with the E-WP.

The forms will be updated as the LTC COVID Response Plan is updated.

Field Manager Responsibility

Field Managers are to conduct the following activities in relation to this procedure:

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

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C. Gathering Data & the Investigation Process

Provider Entrance and Introductions

Upon contact with a provider's staff, the CI will:

1. Provide their name, business card, and general purpose of their visit (i.e., investigating a complaint, checking on the health and safety of residents, etc.).
2. Establish a courteous, respectful, objective, and neutral tone to encourage and facilitate communication and, if necessary, briefly explain the investigative process.
   a. If the administrator or designee is not present, the CI will request they be notified, if applicable.

   Note: In an **ICF/IID**, the CI must notify the administrator or switchboard of their entry into the facility. The CI will request the list of incidents within the last 30 to 90 days from the Electronic Incident Reporting (IR) System, in part, to keep the identity of the persons involved confidential.

Sample Selection

The CI will focus on selecting a sample of residents who are most likely to have conditions, needs, or problems described in the allegation. Based on the size of the provider setting, it may not always be possible to find a sample of residents with similar or the same care needs.

The CI will consider the following factors when selecting a sample:

1. Availability of interviewable and non-interviewable residents.
2. Residents newly admitted to the provider.

   Note: the provider is responsible for providing care from the moment of admission. Choosing a newly admitted resident may give insight on routine practices of the provider.
3. Residents most at risk for neglect or abuse (i.e., residents with a diagnosis of dementia; residents who receive infrequent visitors; residents with behavior problems; residents who are bedbound or are totally dependent on staff for care, etc.)

   Note: In **ICF/IID** and **CCRSS** settings determine if the incident is related to a system failure or was an isolated incident to determine if you need to conduct a sample selection.

Conducting the Investigation

The on-site investigation must be initiated within the priority timeframes established at intake. All initiations must be on-site. Initiation by phone may be considered on a case-by-case basis with approval from the FM. This approval must be documented in the E-WP. Documentation must include date and time approval was given.

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The hardcopy of the CRU intake form must not be taken out of the office at any time. Any other information related to the investigation will always be in the possession of the CI. When on-site at multiple locations on the same day for different investigations, the documents may be secured in the trunk of a locked vehicle. If the vehicle doesn't have a trunk, secure the documents in a locked car so they are not visible from the outside.

The CI must consider when it is necessary to provide the Vulnerable Adult Statement of Rights (VASOR) Form (See Resource B for decision tree).

For Observations, Interviews, and Record Reviews, please see applicable sections.

The role of the CI is to determine whether there are noncompliant practices related to the complaint. The CI will use data gathered during the investigation to determine findings. The order and manner in which information is gathered will depend on the reported concern. Consider critical elements while conducting the investigation, such as:

1. Whether RCS has regulatory authority for every issue in the complaint and if referrals to other agencies are required
2. An accurate set of concerns to investigate and where relevant information may be found (see the section labeled 'Developing an Investigation Plan' for more information).
3. Potential problems or sources of regulatory compliance issues are identified.
4. Possible system issues contributing to a specific failed practice are identified.
5. A representative sample to determine the scope of the failed practice are identified (see the section labeled 'Sample Selection' for more information.)
6. The scope and severity of the identified failed practice(s). CIs have a responsibility to determine if the complaint is reflective of a pattern of behavior.
7. Rules and regulations as they apply to the alleged issue and support failed practice(s).
    a. CIs must always go back and review the language of the specific rule or regulation related to any identified deficient practices to ensure accurate interpretation (see section labeled 'Data Analysis' for more information on the process of assessing findings).

Imminent Safety Concerns – Response During Investigation

The CI's role is to evaluate and assess safety and risk of residents in the setting. If during an investigation it is determined the safety of any resident is at risk the following will occur:

1. The CI will call the FM for implementation of necessary action to protect the residents.
2. If protective action is needed pending the investigation and no action has been taken by the provider, the FM will contact the Compliance Specialist and initiate enforcement action to protect residents.
3. The CI will request action from the provider, and coordinate with their FM on action, to resolve the immediate risk to resident health and safety. Examples of how to resolve the immediate safety concerns include:
    a. Call 911 and/or Law Enforcement (LE).
    b. RCS may ask for a written safety plan from the provider.
    c. RCS may ask for the AP or immediate safety risk be removed from the setting.

Data Analysis

During the process of investigation and data collection, the CI will evaluate findings and ask:

1. Have I verified the findings by a minimum of two data sources (i.e., observations, interviews, and/or record reviews)?
2. Have I tested my conclusions for assumptions?
    a. If an assumption was made, what other information would either validate or change the assumption?
3. Do my facts give clear-cut direction in the decision of compliance?
    a. If not, what other facts or information could make the decision more clear-cut?

Determination of failed practice includes analyzing collected observations, interviews, and/or record reviews to determine if the following questions can be answered:

1. Did the allegation occur?
2. Is the information obtained by observations, interviews, or record reviews consistent?
    a. If there are inconsistencies, is there someone who can explain those or is there evidence to explain the inconsistencies?
    b. If not, ask, "Do I have enough information to verify which story is more likely than not (preponderance)?"
        i. Where could you get more information if needed?
3. Is the information credible?
    a. How do you determine whom to believe?
4. What does the documentation in the record tell you?
    a. Is it accurate?
    b. How do you know?

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5. Do the findings support each other?
6. Would other facts clarify the situation?
7. Who or which provider staff member was closest to providing the services or care in question?
8. What other records could be reviewed to clarify the situation?
9. Are other observations needed?
10. Was the investigation thorough and in accordance with regulatory requirements?

The CI must compare findings to the regulatory requirements. In doing so, consider the following:
1. Is there failed practice or more than one failed practice?
2. If "yes", what is the scope and severity of each failed practice?

The CI will consider the strength of the investigative evidence, to include:
1. What types of observations demonstrate what was or was not happening?
2. What did the resident think?
3. Which staff persons might have information and should be interviewed?
4. What single piece of the record would provide information about what was done or what should have been done?

If the CI has determined harm of a resident, the CI will determine the following:
1. Did the provider recognize and address trends or patterns?
2. If there are system problems, have they been corrected?
3. Did the provider identify the resident to be "at risk" or should they have?
   a. Consider tools such as assessments and care plans.
4. Did the provider develop interventions addressing risk factors?
   a. Consider tools such as care plans.
5. Did the provider implement preventive measures as planned?
6. Did the provider have systems in place to ensure provision of preventive measures?
   a. Consider quality assurance programs, staff training, staff qualifications, investigations, supervision, etc.
7. Did the provider respond timely, including protecting of the resident as necessary?
8. Was acute, clinical management provided as needed for medical, physical, and/or psychological issues?
9. Were interventions consistent?
10. Were interventions re-evaluated for effectiveness?
11. Were outcomes avoidable or preventable?
12. Did the resident experience additional harm because of the provider's compliance failure?

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If an additional concern(s) is reported during the course of the investigation, the CI must report in accordance with the processes outlined in the section labeled 'Filing a Complaint Intake from the Field'.

Status Report on Exit

The CI will review issues and preliminary findings with the administrator or designee, including but not limited to:

1. Preliminary findings and identified deficiencies. Inform the provider of possible need for further data collection. Preliminary findings may change if additional information affects the outcome of the investigation.
2. Inform the administrator or designee they will be contacted by telephone or email to confirm the final outcome and closure of the investigation (see section labeled 'Outcome Conference' for more information).
3. Allow the provider an opportunity to discuss the investigation, ask questions, and present related additional information.
4. Ensure that the provider is aware of resident issues in need of immediate attention.
5. Inform the provider of the Statement of Deficiencies (SOD) process, including:
    a. SOD will be sent within 10 working days from the last date of data collection (See section labeled 'Final Determination' for more information).
    b. Will include a cover letter explaining if a plan of correction (POC) is required.
    c. Provider requirement to send back a POC within 10 calendar days of SOD receipt.
    d. Informal Dispute Resolution (IDR) process.

    Note: In the **Nursing Home** program, this is also the Outcome conference, which starts the 10-working day timeline.
6. Present the provider with their business card as well as contact information for the FM. Inform the provider that the FM may be a resource for questions regarding the findings.

    Note: In a **CCRSS** setting, this conversation will likely occur over the phone since the CI may no longer be on-site and the Administrator often is not physically present either. The CI must contact the Administrator via telephone and contact information should be provided verbally. If a message is left, include this information in the message.
7. Thank the provider for their cooperation with the investigation.

The CI will document the status report conversation, including any plans disclosed by the provider intended to ensure resident safety, in the E-WP.

D. Off-site activities

Final Determination

1. The CI may need to interview independent sources to obtain relevant information after the on-site investigation is completed.
    a. These sources are not required to be part of each investigation and will be kept to the minimum needed to validate information without overly extending the time it takes to complete the investigation with the support information.
    b. All contacts must be made within seven (7) days of exit from the provider, unless receiving approval from the FM to extend this time frame.
    c. If additional contacts are made after the on-site investigation is completed, the date of last contact will be the last date of data collection.
2. The CI will review and analyze all data pertinent to the complaint and determine if there is failed practice.
    a. If failed practice is identified, the findings will be documented in detail to create a relevant narrative within the Statement of Deficiency (SOD) based on identified rules and regulations (see the section labeled ‘Statement of Deficiencies’ for more information).
3. The CI will coordinate any enforcement recommendations with the FM.

Outcome Conference

The CI will document the following when informing the provider of the outcome of the investigation:
1. The date and time of the call or meeting with the provider when summarizing the investigation outcome.
2. The name and title of the person to whom the information was provided. Offer to review with the provider any appropriate regulatory requirements related to the deficiency or nature of the findings.
3. Whether failed practice was identified.
4. If the provider is unavailable the CI will document the date, time, and summary of the message left.

Public Complainants (PCs) and Outcome Letters

1. The CI will contact the PC to summarize the investigative findings and inform them an Investigation Summary Report (ISR) will follow if they requested one.
   Note: the PC must be contacted even if they did not request an outcome report. This includes hospital staff and first responders. Document in the E-WP the date and time of contact. If the PC is unavailable, it is appropriate to leave a message provided the message does not contain confidential information.

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Referrals

If the CI identifies a concern that requires a report to another agency, the CI will make all necessary referrals in accordance with procedures established in RCS SOP Manual, Chapter 4 – Complaint Resolution Unit. Agencies may include:

- Law Enforcement (LE)
- Adult Protective Services (APS)
- Medicaid Fraud Control Division (MFCD)
- Department of Health (DOH) – licensing boards
- Department of Children, Youth, and Families (DCYF)

Statement of Deficiencies (if applicable):

The CI will:

1. Review all pertinent investigative findings and confirm the analysis of deficiency citations.
2. Conduct a review with the FM as other questions arise.
3. Write the SOD in accordance with the Principles of Documentation.
4. Issue the SOD to the provider within ten (10) working days of the last date of data collection.
   Note: For **Nursing Homes** and **ICF/IID** programs, the SOD must be issued to the provider within ten (10) working days of the exit. For the **Nursing Home** program, SODs are posted by the FM or designee into the e-POC system. If a citation results in Scope/Severity at a G level or higher (harm), the written citation must go to the Enforcement and Compliance Unit for review.
5. Coordinate with the FM if enforcement action is recommended and follow RCS SOP Manual, Chapter 7 – Enforcement.
   Note: If Enforcement is necessary, the SOD must be provided to enforcement and compliance staff for review by the 6th working day, prior to being sent to the provider. SODs can be submitted to rcscomplianceunit@dshs.wa.gov.
6. Enter the SOD into the respective system based on the program type:
   a. AFH, ALF, ESF, CCRSS: STARS
   b. Nursing Homes, ICF/IID: ASPEN/ACTS, STARS
   Note: While the SOD is generated within ASPEN/ACTS, the Compliance Determination (CD) will still need to be completed in STARS in order to be closed and to issue the ISR (see STARS Manual for Federal Programs for more information).
7. Notify the FM when the SOD has been entered into program specific tracking program (mentioned above). Notification is completed by sending the CD to the FM for review in STARS (see STARS Manual for Community Programs or STARS Manual for Federal Programs for more information).
   Note: It is crucial all approvals be tracked in the STARS system, as this provides evidence of compliance with timelines.

See sections labeled 'Field Manager Responsibilities' and 'Administrative Assistant Responsibilities' for next steps in this process.

Investigation Summary Report

The Investigation Summary Report (ISR) provides a brief summary of the investigative activities conducted in response to a complaint (see section labeled 'Investigation Summary Report Details' for an example of how to complete the ISR). ISRs are meant for public view and are publicly disclosable. The ISR must clearly articulate the outcome of the investigation. It must be objective and concise while avoiding repeating the specific, detailed information contained in the Statement of Deficiency (SOD) (if applicable).

The CI will:

1. Complete the ISR within 15 working days of the last day of data collection for each complaint investigated. Timeframes will only be extended with documented approval from the FM.
2. Never write the ISR prior to the last day of data collection.
3. Not send the ISR until the SOD has been received by the provider.
4. Complete a separate ISR for each intake.
    a. When multiple intakes are investigated within the same on-site visit, each ISR will only include information from the referenced intake. It must not reference information or violations from the other intakes investigated within the same on-site visit.
5. Maintain confidentiality of all parties throughout the ISR, identifying individuals only by generic pronouns such as they or them.
6. Not use the reference “see intake” in lieu of the description of the allegations.
    Note: Intakes are confidential and cannot be viewed by the public.
7. Not mention investigations by any other agencies, such as Adult Protective Services (APS), Medicaid Fraud Control Division (MFCD) or Department of Children, Youth, and Families (DCYF).
8. Include only information documented or supported by information found in the E-WP.
9. Never include their opinion.

Field Manager Responsibilities

Review the SODs and ISRs for compliance with regulations and guidelines. Provide oversight of investigation documentation by conducting periodic reviews on their staff’s E-WP to ensure policies and procedures are followed, requesting clarification from RCS leadership as needed.
Note: The FM may decide to appoint a designee (i.e., the AA) for the activities identified with *.

1. SOD must be reviewed for the following:
    a. Compliance with the Principles of Documentation.
    b. Findings are supported by the evidence.
    c. Scope/severity of the deficient practice is identified.
    d. *Identifying information is not included.
    e. Does not include extraneous information irrelevant to non-compliance, including diagnoses and medications.

2. ISRs must be reviewed for the following:
   a. Allegation description accurately captures the reported concern. The CI should never use ***only*** the STARS category assigned in the intake.
   b. *If there is more than one allegation, the allegations are sequentially numbered both in the allegation description and in the investigation summary.
   c. *Acronyms are explained.
   d. *All medical jargon is explained.
   e. *No identifying information is included.
   f. Summary is brief and clear.

Administrative Assistant (AA) Responsibilities

The AA or designee will:

1. Mail the SOD to the provider via USPS Certified Mail with Return Receipt Requested for all settings. The tracking information will be recorded in STARS (see STARS Manual for Administrative Assistants for more information).
   a. If the SOD is not being mailed until the 9th or 10th day, the AA will fax or email (via whichever method available) the SOD in addition to mailing it.
   b. It is also acceptable for staff to deliver SODs in person when necessary. The SOD must still be mailed via above mentioned method.
2. Mail the following to the PC if the “Follow-up” requested box is checked on the intake (this indicates the PC requested notification of the investigation outcome):
   a. Public Outcome Letter generated through STARS.
   b. Copy of the ISR.
      Note: The ISR must not be sent until the provider has received the SOD report.
   c. Copy of the document “How to Read Your RCS Investigation Summary Report,” if applicable.
      Note: If the PC requests a copy of the SOD, a public disclosure request must be submitted to pdd@dshs.wa.gov.

   Note: Many PCs prefer to receive this information electronically rather than in paper form.

E. Complaint Closure

A complaint investigation is considered closed with the following has been completed:

1. All data has been entered into the appropriate tracking systems.
2. All reports have been approved by the FM.
3. All required reports and letters have been sent.
4. Any applicable follow up visits (on-site or off-site) have been completed.
5. 'Back in Compliance' (BIC) letter has been sent to the provider.
   Note: This step is not applicable for the **CCRSS** program. For the CCRSS program, the POC will be reviewed, and an on-site follow-up visit conducted to determine if the provider is back in compliance. This can take a minimum of 45 days.

Documentation from the Complaint Investigation is to be archived per the following process:

1. Hard copy documents (i.e., signed SODs, certified mail receipts, enforcement actions, etc.) must be sent to Central Files within 10 working days after the complaint investigation closed.
2. All E-WP must be closed and transferred to Perceptive Content within 30 days of complaint closure (see E-WP Quick Start Guide for more information).

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Part II: Resources and Additional Guidance

A. Vulnerable Adult Statement of Rights (VASOR) Form

The CI will give the Vulnerable Adult Statement of Rights (VASOR) Form to the AV or their legal representative if the allegation is determined to be related to a report of abandonment, abuse, financial exploitation, or neglect of a vulnerable adult per RCW 74.34.305.

A VASOR form must be given with each new complaint. However, only one VASOR is required per complaint, even when the vulnerable adult is interviewed multiple times.

If needed to keep the identity of the AV confidential, give the form to all residents who are interviewed.
Note: In **AFH** settings, a VASOR must be provided to every resident to protect the AV's confidentiality.

It is permissible for the CI to give both the resident and their legal representative copies. If one refuses, the VASOR must be given to the other.

The VASOR must be provided to the resident under the following circumstances:
1. When the resident is available for an interview.
    a. If unavailable for interview, the VASOR may be left in their room.
2. The form must be provided even when the resident is cognitively impaired.

The VASOR must be provided to the legal representative within 10 days of the on-site visit by the CI. When mailed, a cover letter must accompany the VASOR (see 'Sample Cover Letter' below). Give the legal Representative a VASOR under the following circumstances:
1. The resident is unavailable for an interview.
2. The resident refuses to accept the form or provide a mailing address.
3. The resident is hospitalized.
4. The resident is deceased.

A VASOR is not required to be given to the resident or their legal representative in the following circumstances:
1. If the vulnerable adult refuses and there is no legal representative.
2. If both the vulnerable adult and the legal representative refuses.
If the vulnerable adult is deceased and there is no legal representative.

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Under all circumstances, the CI must document in the E-WP the date the VASOR was given, the person(s) to whom the VASOR was provided and why a VASOR was/was not given.
Note: In the **AFH** setting, if a VASOR was provided to all residents, it is acceptable to indicate that rather than listing each resident individually. All other documentation noted is still required.

There are two different forms depending on which setting the complaint investigation is conducted:
1. DSHS 16-234A for CCRSS (Supported Living) and ICF/IID that are RHCs (Rainier School, Lakeland Village, and Fircrest).
2. DSHS 16-234 for all other settings (NH, AFH, ALF, ESF, non-RHC ICF/IIDs).

Sample Cover Letter:

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Aging and Long-Term Support Administration
PO Box 45600, Olympia, WA 98504-5600

Date

Dear Legal Representative,

Washington State Law (RCW 74.34.305) specifies that when the department opens an investigation of a report of abandonment, abuse, financial exploitation, or neglect of a vulnerable adult, the department shall provide a written statement of rights to the alleged victim(s) or legal representative.

This document is being sent to you as the identified legal representative for first/last name of client. We may have previously spoken to you or you received a phone call/voicemail about our current investigation, this document, and the reason for our contact. Our goal is to ensure you and the vulnerable adult in which you are responsible for are aware of your rights while we are conducting an investigation of alleged provider practice noncompliance concerns.

The enclosed document provides you with an explanation of your rights. If you have any questions, please contact {Field Manager}, Residential Care Services, at (XXX) XXX-XXXX.

Sincerely,

Field Manager or Investigator Name
Title, Program
Residential Care Services

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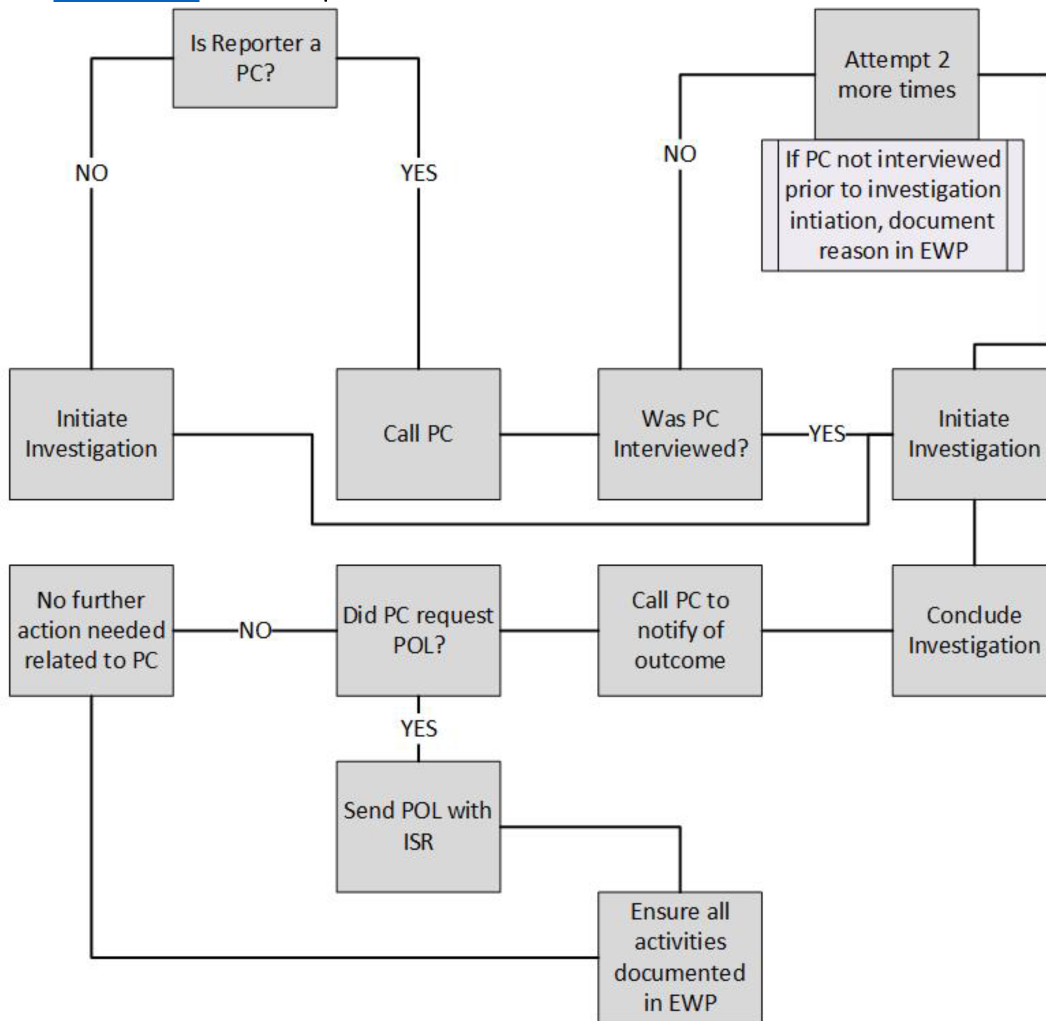
B. Public Complainant (PC) Decision Tree

See Appendix E for examples of documentation related to PC contacts.



Acronymns
EWP – Electronic Working Papers
PC – Public Complainant
POL – Public Outcome Letter
ISR – Investigation Summary Report

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C. Filing a Complaint Intake from the Field

If, during an investigation, an individual approaches the CI with concerns regarding the health or safety of a resident, the CI must evaluate the nature of the complaint and follow these procedures:

1. The CI will give the PC the RCS Complaint Resolution Unit (CRU) toll-free phone number (1-800-562-6078) and provide instructions on how to submit a report.
2. The CI will provide mandated reporters (such as state agency employees, county employees, etc.) the CRU email (cru@dshs.wa.gov).
3. RCS staff will report all concerns directly to the CRU email.
4. If needed, the CI will consult with their FM.

When RCS staff are making a mandated report, Chapter 74.34 RCW requires a report with the following information, if known, be made immediately to CRU:

1. The name and contact information of the person making the report.
2. The name and address of the AV.
3. The name of the provider providing care to the AV, as well as the address if different.
4. The name and contact information of the legal guardian or alternate decision maker.
5. The nature and extent of the abandonment, exploitation, abuse, or neglect.
6. Any history of previous abandonment, abuse, exploitation, or neglect.
7. Identity of the AP when known, as well as any professional licensure information if applicable.
8. Any other information helpful in establishing the extent of the abuse, exploitation, neglect, or the cause of death if the AV is deceased.

If there are serious concerns or if any resident of the provider is in harm's way, the CI will notify law enforcement immediately if needed, followed directly by a notification to CRU and then notice to the FM. Once all notifications are completed, the CI will initiate an appropriate and immediate investigation. See section labeled 'Imminent Safety Concerns-Response During Investigation' for more information.

Note: The lack of an assigned complaint number or completed intake form shall not delay initiation of an investigation.

D. Use of Photography

Photography can be a useful tool for documenting evidence. The need for photographic evidence may occur during a complaint investigation. Photographs are not a substitute for documenting observations, interviews, or record reviews. Photographs are not (and should not become) a routine part of the inspection or investigation process.

The CI is not required to have specialized training in photography prior to photographing evidence. The CI must follow all steps outlined below when preparing to photograph and when handling the photographs upon return to the office.

Preparation Before Using Photography & Associated Processes

The CI will:

1. Consult with the FM about plans for photographing and explain the specific situation.
2. Always preserve resident rights, privacy, and dignity.
3. Have equipment readily available and easy to access.
4. When using a state- issued digital camera, secure the equipment either on their person or in a locked car while conducting the investigation. Return the camera to a secure location in the office after completing the investigation.
5. When using a state-issued cellular phone to take photographs, send the pictures to your state email **immediately,** with a CC to the provider using secure email (refer to DSHS Information Security Manual for more information. This maintains the integrity of the photo and avoids a time-lapse that could create a potential perception the photo may have been altered.
6. Verify, on the same day the picture was taken, that you and the provider received the photo via email. Once verified, delete the photo from your state-issued cellular phone.
7. Never use a personal cellular phone for state business.
8. Obtain consent from the resident or their legal representative prior to photographing unless:
   a. Immediate photographing is necessary to preserve evidence; or
   b. The legal representative is the AP.
9. Use the Photography Release Form to document permission or refusal.
10. Obtain permission from the resident or their legal representative prior to photographing the resident’s room or resident’s possessions.
11. The CI does not need to obtain consent from the provider to photograph the environment but will notify the provider when taking photos of the environment.
12. Request a provider staff member be present when taking photos of the resident. Document the name and title of the provider staff member.

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13. When taking pictures with measurements of certain markings on a resident (i.e., bruises, break in the skin), use a disposable tape measure or laser measure when photographing markings on a resident. The CI will not touch the resident but rather place the measuring device next to the site in question or have the provider's staff assist in holding the measuring device above the area.
    Note: The FM can inform the CI of the process of obtaining the measuring device (tape or laser) at their local field office.
14. For photographs of a resident's condition, The CI must use the macro to micro technique. Take a series of pictures to include:
    a. Outside of residence to show address or location of resident;
    b. Picture of the resident in the environment; and
    c. Photographs of any specific markings, bruising or resident's condition.

The FM will:

1. Develop a system to ensure the following information is maintained for every photograph taken by digital camera or state-issued cellular phone:
    a. Who took the picture.
    b. Who/what is the subject of the photograph.
    c. Date and time the picture was taken.
    d. The Compliance Determination (CD) identification number (if applicable).
2. Develop a procedure for securing and checking out all digital cameras.
3. Assure measuring devices (either disposable tape or laser) are always available.
4. Work with the local Information Technology (IT) staff to create a system for processing and storing photos.

After Photographing with a Digital Camera

The CI will:

1. Utilize the system developed by their field office to transfer photographs from the digital camera to a designated secure electronic folder located in the field office's shared drive.
2. Delete the photographs from the camera AFTER assuring all photographs have been transferred.
3. Make a notation on the E-WP that photographs are associated with the investigation. Document the location of the photographs.
4. Store any hard copies of photographs in a secure manner (i.e., in a location precluding access by unauthorized persons) according to field office procedures.

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If sharing with others (such as the AAG's office):

1. Document the name of the recipient and sufficient information to identify which photographs were shared.
2. Do not send a photocopy of the photograph. An original copy must be printed from the electronic file.
3. Include a narrative description with the photograph.
4. Assure all information is transferred in a confidential manner.
5. Follow RCS guidelines for record retention of the photographs.

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E. Coordination and Communication with Adult Protective Services (APS)

This section is meant to provide RCS staff with direction for coordination, communication, and sharing information with Adult Protective Services (APS) during investigations involving individuals alleged to have been abandoned, abused, neglected, or financially exploited, including misappropriation of their property.

With all allegation types, except physical or sexual abuse, APS will not investigate until RCS has begun investigating and notified APS there is a need to complete an investigation. APS will screen out any initial intake referrals made by CRU. It is crucial the CI make a new referral to APS when there is reason to believe abandonment, abuse, neglect, or financial exploitation occurred.

Making Reports to APS:

In cases where only RCS is assigned to investigate and information indicates a need to involve and/or coordinate the investigation with APS, the CI will:

1. Contact CRU and make a report if there is reasonable cause to suspect abuse, neglect, or exploitation may have occurred.
    a. If unsure if a report is required, the CI may consult with their FM.
    b. If there is doubt about whether a report to CRU is needed, it is better to make the report.
2. Collaborate with APS, keeping the FM informed of any updates.
3. Document in report RCS has begun their investigation, and APS involvement is requested. This will avoid a potential screen out of the intake.

Coordination

The FM and Compliance Specialist may, at their discretion, request a meeting with the APS supervisor to discuss issues with the investigation and/or potential enforcement action.

Notification of APS Findings

APS will inform the FM or CI of the outcome from the APS investigation, including any appeal order. Refer to Long-term Care Manual Chapter 6: APS for guidelines on APS investigations.

The FM will notify the Compliance Specialist of the outcome from the APS investigation.

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Enforcement Actions

Compliance Specialist will search the name of the individual in the ADS Registry for possible enforcement action.

F. Reporting Criminal Neglect (also known as Criminal Mistreatment):

The CI must consider if the actions or inactions of the provider or AP raise suspicion of criminal mistreatment or criminal neglect. The key to effectively identifying potential criminal neglect is to identify those situations when a person or entity has a duty of care and may have either recklessly or negligently withheld a basic necessity of life. That withholding or failure to act then creates an imminent and substantial risk of death, great bodily harm, substantial bodily harm, or extreme emotional distress for the resident or client.

RCS must report to LE and the MFCD whenever there is reason to suspect that criminal mistreatment or criminal neglect has occurred. The determination of whether a person had the requisite criminal intent when they caused the injury to a resident is a legal determination that must only be made by a prosecuting attorney.

The CI will:

1. Review Criteria in Criminal Mistreatment Indicators (See Appendix C);
2. Make timely referrals;
3. Communicate effectively with law enforcement and the MFCD; and
4. Inform and update the FM about coordinating investigative activities with LE.

During any investigation, there may be multiple points in time at which a referral to LE and/or MFCD may be needed. These points of time include:

1. At initial intake.
2. During the initial on-site visit to the provider, when the CI finds circumstances to be of greater seriousness, or markedly different than the original report to CRU had indicated.
3. During the writing of the Statement of Deficiencies (SOD), when managers or staff notice a pattern to the areas of a citation with indicators of criminal neglect.
4. During enforcement activities.

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CI/Licensor Responsibilities

1. Familiarize themselves with the criteria for identification of situations indicative of criminal neglect (see 'Criminal Mistreatment Indicators').
2. Document detailed investigative notes and use quotes when documenting any statements from witnesses.
3. Assist LE to understand what resident care should have been provided. Advise LE of potential witnesses.
4. Document observations of the demeanor of licensees or caregivers.
5. Take any photographs of the resident consistent with the section labeled 'Use of Photography'.
6. Inform LE and FM on the progress of the investigation.
7. Provide LE timely access to all records obtained during the normal course of RCS investigative work. As needed, help LE understand and interpret RCS records.

Communication Between Investigating Entities

1. FMs are the initial and primary contact points between LE, MFCD, and RCS staff.
2. During an on-site investigation, if a CI calls 911 to report criminal neglect, the CI must also notify the FM.
3. It is an expectation CIs will apprise the FM of any interactions/follow-up discussions or coordination activities with LE or the MFCD.

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G. Protection of Resident Privacy and Data Security

Background

This Standard Operating Procedure provides guidance to assure that resident-specific data is exempt from public inspection and copying, or inadvertent disclosure.

1. A major goal of both federal and state privacy laws is to assure that resident health information is properly protected, while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being.
2. Health care information is personal and sensitive information. If improperly used or released, it may do significant harm to a resident's interests.
3. A central aspect of federal and state privacy rules is the principle of "minimum necessary".
4. To retain the full trust and confidence of residents, the department must assure that health care information is not improperly disclosed.
5. While conducting complaint and incident investigations, department staff will implement reasonable safeguards for the security of all resident health care information.
6. Individually identifiable resident information is information, including demographic data, that relates to:
   a. The individual's past, present or future physical or mental health or condition,
   b. The provision of health care to the individual, or
   c. The past, present, or future payment for the provision of health care to the individual, and
   d. That identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security number, etc.).

Procedures

1. RCS staff must not take either the original Complaint Resolution Unit (CRU) intake form or a copy of the intake into the provider while conducting investigation activities.
2. Investigators will not routinely make copies of resident records but keep any copying to the "minimum necessary".
3. During the course of a complaint investigation, if the investigator makes any copies of resident records with individually identifiable resident information, copies will not be left unattended in a vehicle at any time.
4. If theft of any investigator's personal property or department owned equipment results in the potential for inadvertent disclosure of resident individually identifiable health information, immediately contact the FM and consult with the Assistant Director as indicated.

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Part III: Appendices

A. Glossary of Terms

Administrator or designee – Includes the various titles of the responsible person(s) for the provider. This list includes but is not limited to superintendent, director, provider, program manager, individual or entity representative, resident manager, administrator, or executive director.

Allegation – A statement (claim, assertion, witnessing) or an indication made by someone (regardless of capacity or decision-making ability) indicating abuse, neglect, exploitation, or misappropriation of a vulnerable adult's property may have occurred and as such requires a thorough investigation.

Basic Necessities of Life – This means food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen, and medication. WAC 388-103-0001(5).

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.

Chemical Restraint – Refers to the administration of any drug to manage a vulnerable adult's behavior in a way that reduces safety risk to the vulnerable adult or others, has a temporary effect of restricting the vulnerable adult's freedom of movement, and is not standardized treatment for the vulnerable adult's medical or psychiatric condition

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.

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

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

Duty of Care – This includes:

(a) A guardian or conservator appointed under chapter 11.88 RCW or chapter 11.130 RCW;

(b) An agent granted authority under a power of attorney as described under chapter 11.125 RCW; or

(c) A person providing the basic necessities of life to a vulnerable adult where:

- (1) The person is employed by or on behalf of the vulnerable adult; or
- (2) The person voluntarily agrees to provide, or has been providing, the basic necessities of life to the vulnerable adult on a continuing basis.

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.	
Fact – An event known to have actually happened. A truth that is known by actual experience or observation.	
Facility/Home/Provider – Refers to the following statutes: RCW 74.34.020(5), these terms refer to a residence licensed or certified under Chapter 18.20 RCW (Assisted Living Facilities); Chapter 70.97 RCW (Enhanced Services Facilities); Chapter 18.51 RCW (Nursing Homes); Chapter 70.128 RCW (Adult Family Homes); Chapter 72.36 RCW (Soldiers' Homes); or Chapter 71A.20 RCW (Residential Habilitation Centers); or any other facility licensed or certified by the Department.	
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."	
Finding – A term used to describe each item of information found during the regulatory process about provider practices relative to a specific requirement cited as being not met.	
Health Care – The care, services or supplies related to the health of a vulnerable adult, including, but not limited to, preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, counseling for a physical or mental condition, a prescribed drug, device, or equipment.	
Incident – An official notification communicated to RCS's CRU from a self-reporting provider/provider representative that RCS licenses or regulates. Owners, operators, and managers of facilities must self-report incidents and/or allegations of vulnerable adult abuse, abandonment, financial exploitation, sexual abuse, physical abuse, mistreatment, neglect, and/or misappropriation of a vulnerable adult's property as outlined in Chapter 74.34 RCW, Abuse of Vulnerable Adults. Nursing homes must also report vulnerable adult injuries of unknown origin and any other requirements outlined in WAC 388-97 (Nursing Homes).	
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.	
Licensee or designee – A generic term to describe individuals/entities/providers licensed or certified to provide adult family home, assisted living facility and/or nursing home care in the state of Washington.	
Legal Representative—A generic term which includes the resident representatives who act on behalf of the resident concerning care and services provided by the facility, home, or provider. This would include power of attorney, surrogate decision-maker, guardian, or any other person authorized by law to act for another person.	
Long-term care facility – As defined in RCW 70.129.010(3), this term refers to a facility licensed or is required to be licensed under Chapter 18.20 RCW (Assisted Living Facilities), Chapter 70.97 RCW	

(Enhanced Services Facilities), Chapter 72.36 RCW (Soldiers' and Veterans' Homes), or Chapter 70.128 RCW (Adult Family Homes).

Mandated Reporter – As defined in RCW 74.34.020(8), this is an employee of the Department; law enforcement; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to Chapter 18.130 RCW.

Mechanical Restraint – Refers to any device attached or adjacent to the vulnerable adult's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body. "Mechanical restraint" does not include the use of devices, materials, or equipment that are (a) medically authorized, as required, and (b) used in a manner that is consistent with federal or state licensing or certification requirements for facilities, hospitals, or programs authorized under Chapter 71A.12 RCW.

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.

Outcome – In this context, the term means an actual or potential result or consequence, directly or indirectly, related to failed facility practices of the licensee or designee. Harm to vulnerable adults unrelated to failed facility practice is not a negative outcome for the purpose of RCS complaint/incident investigation processes.

Permissive Reporter – This refers to any person, employee of a financial institution, attorney, or volunteer in a facility or program providing services for vulnerable adults.

Physical Restraint – Refers to the application of physical force without the use of any device, for the purpose of restraining the free movement of a vulnerable adult's body. "Physical restraint" does not include (a) briefly holding without undue force a vulnerable adult in order to calm or comfort them, or (b) holding a vulnerable adult's hand to safely escort them from one area to another.

Practitioner – The term includes a licensed physician, osteopathic physician, podiatric physician, pharmacist, licensed practical nurse, registered nurse, advanced registered nurse practitioner, dentist, and physician assistant. Refer to Chapter 69.41 RCW for a complete listing of practitioners.

Priority Definitions – For both complaints and incidents, the period of actual time by when those investigations shall be initiated on-site within a specified number of days from receipt in the RCS's Regional units (See Ch. 4 for more information):

- **2-Working Days** – This is an allegation of a life-threatening situation that has caused, or is at risk of causing, substantial harm of such consequence urgent intervention is necessary.
- **10-Working Days** – This is an allegation of a situation that has caused harm, injury, or impairment to the vulnerable adult. A timely response is indicated because the situation is present and ongoing, or there is high potential for reoccurrence of the incident.
- **20-Working Days** – This is an allegation of a situation that is not likely to reoccur, but if it did, would pose a risk of potential harm to a vulnerable adult. The provider/facility may have

investigated the situation and initiated corrective action. Investigation by RCS is required because of the need to determine whether the provider's systems are intact.

- **45-working days** – This is an allegation of a situation that commonly involves the failure to provide general care and services. The vulnerable adult has experienced no more than discomfort, and no significant impairment to physical, mental, or safety status.
- **90-working days** – Complaint investigation may be delayed if the allegation is general in nature, anonymous, and a survey/inspection is scheduled within 90 working days. In general, this is a priority assignment made by the Field Manager, not by the CRU. Complaint issues in this category do not meet the criteria for a 2, 10, 20, or 45 working days assignment.
- **Quality Review** – This is a reported allegation where the provider appears to have taken appropriate action in response to the situation, and measures have been instituted by the provider to prevent reoccurrences. All appropriate parties have been notified, including professional licensing boards (if appropriate). Allegations may also receive a "Quality Review" designation if another report of a more urgent nature has already prompted an investigation of the situation by the Department. (On-site investigation is not indicated by this intake).

Reporter or 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*, *Law Enforcement*, *State Employee*, or *Anonymous*.

- Public reporters are generally residents or clients, family of residents or clients, Long Term Care Ombudsman staff, hospital staff, teachers, or other members of the public. Facility staff may be considered public reporters when it is clear they are not making an official facility report or are reporting as whistle blowers.
- Facility reporters 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.

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

Statement of Deficiencies (SOD) – The official 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.

Vulnerable adult – Comprehensively defined in RCW 74.34.020, includes a person:

a) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or
b) Subject to a guardianship under RCW 11.130.265 or adult subject to conservatorship under RCW 11.130.360; or
c) Who has a developmental disability as defined under RCW 71A.10.020; or
d) Admitted to any facility; or
e) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under Chapter 70.127 RCW; or

f) Receiving services from an individual provider; or
Who self-directs his or her own care and receives services from a personal aide under Chapter 74.39 RCW.

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B. Acronym List

AA	Administrative Assistance
ACTS	ASPEN Complaints/Incidents Tracking System
AFH	Adult Family Homes
ALTSA	Aging and Long-Term Support Administration
APS	Adult Protective Services
ASPEN	Automated Survey Processing Environment System
ALF	Assisted Living Facilities
AP	Alleged Perpetrator
AV	Alleged Victim
CARE	Comprehensive Assessment and Reporting Evaluation System
CC	Collateral Contact
CCRSS	Certified Community Residential Services and Supports
CHOW	Change in Ownership
CI	Complaint Investigator
CS	Compliance Specialist
DDA	Developmental Disabilities Administration
DOH	Department of Health
ESF	Enhanced Services Facilities
E-POC	Electronic Plan of Correction
E-WP	Electronic Working Papers
FM	Field Manager
FMS	Facility Management System
HCS	Home and Community Services
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
IPC	Infection Prevention and Control
ISR	Investigation Summary Report
LTC	Long Term Care
MAR	Medication Administration Records
MFCD	Medicaid Fraud Control Division
MH	Mental Health
NH	Nursing Homes
PC	Public Complainant
POC	Plan of Correction
POL	Public Outcome Letter
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington

RHC	Residential Habilitation Centers
SOD	Statement of Deficiency
SOP	Standard Operating Procedures
STARS	Secure Tracking and Reporting System
VASOR	Vulnerable Adult Statement of Rights
WAC	Washington Administrative Code

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C. Criminal Mistreatment Indicators

Report to law enforcement and the Medicaid Fraud Control Division (MFCD) whenever there is reason to suspect that criminal mistreatment has occurred.

The determination of whether a person had the requisite criminal intent when they caused the injury is a legal determination that must be made by a prosecuting attorney.

Presence of one (1) or more of the following are potential indicators of criminal mistreatment.

- Pressure ulcers
  - Stage III or IV Pressure Ulcers
  - Untreated; infected, odorous, eschar
  - Improperly treated
  - On locations indicating improper placement i.e., on front of body
- Urine burns
- Unexplained fractures
- Rapid weight loss
- Significant dehydration
- Withholding food
- Lack of treatment causing significant injury or death, or the risk thereof
- Significant injury or death following a fall
- Contractures developed while in the provider's care
- Withholding or limiting oxygen contrary to physician's orders
- Malnutrition (unless caused by resident's underlying disease)
- Repeated infections at site of catheter, etc.
- Unsanitary living conditions that pose significant danger to residents
- Repeated falls (two or more falls in a one-month period)
- Bruising or other injury to face, neck, ears, trunk, back, genitalia, buttocks, or soles of feet
- Reports of falsified records
- Insufficient staffing that negatively impacts residents
- Use of restraints when none are indicated
- Missing multiple medical appointments (two or more in a two-month period)
- Untreated medical or mental conditions
- Withholding assistive devices (walker, wheelchair, glasses, hearing aide, etc.)
- Inappropriate medication (too much, too little, or contraindicated)
- Delayed treatment causing significant injury or death, or the risk thereof

Criminal Mistreatment Defined
Causing or creating an imminent and substantial risk of one of the following by withholding any basic necessity of life: • Death • Great bodily harm • Extreme emotional distress • Substantial bodily harm • Bodily harm/injury
Other Definitions
Basic necessities of life – Food, water, shelter, clothing, and medically necessary health care, including but not limited to health-related treatment or activities, hygiene, oxygen, and medication.
Great bodily harm -- bodily injury which creates a high probability of death, or which causes serious permanent disfigurement, or which causes a permanent or protracted loss or impairment of the function of any bodily part or organ.
Substantial bodily harm -- bodily injury which involves a temporary but substantial disfigurement, or which causes a temporary but substantial loss or impairment of the function of any bodily part or organ, or which causes a fracture of any bodily part.
Report any suspected crime to law enforcement and the MFCD. **To report to the MFCD, or if you have questions concerning criminal mistreatment, contact: (360) 586-8888 or mfcureferrals@atg.wa.gov**

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D. Investigation Summary Report Details

Residential Care Services

Investigation Summary Report

Provider/Facility: NAME OF FACILITY/HOME/PROVIDER
License/Cert.#: LICENSE # OR CERTIFICATION # OF PROVIDER
Compliance Determination #: STARS COMPLIANCE ID
Investigator: NAME OF PERSON(S) WHO INVESTIGATED COMPLAINT AND WROTE ISR

Provider Type: PROVIDER SETTING TYPE
Intake ID: CRU INTAKE # (1 INTAKE ID PER ISR)
Region/Unit #: REGION / UNIT THE PROVIDER IS ASSIGNED TO AT THE TIME OF INTAKE

Investigation Date(s): DATES AUTO FILLED THE INVESTIGATOR WAS FIRST ON-SITE THROUGH THE LAST DATE OF DATA COLLECTION
Complainant Contact Date(s): DATES AUTO FILLED FROM PROVIDER NOTES WHEN THE ACTIVITY "COMPLAINANT CONTACT" IS SELECTED. DETAILS OF THE CALL (LEFT MESSAGE, NO ANSWER, ETC.) WILL NOT COPY OVER TO THE ISR BUT WILL REMAIN IN STARS

Allegation(s): ALLEGATIONS, CONCERNS, ISSUES, OR COMPLAINTS ABOUT THE NAMED FACILITY/HOME/PROVIDER RECEIVED AT INTAKE OR DURING THE INVESTIGATION. DESCRIPTIONS SHOULD FOCUS ON THE GENERAL NATURE OF THE ALLEGED ISSUE. IF THERE IS MORE THAN ONE ALLEGATION, THE ALLEGATIONS MUST BE SEQUENTIALLY NUMBERED (i.e., 1,2,3)

Investigation Methods: IDENTIFIES THE SOURCES OF INFORMATION COLLECTED BY THE INVESTIGATOR WHILE INVESTIGATING ALLEGATIONS, CONCERNS, ISSUES, OR COMPLAINTS. SELECT THE APPROPRIATE METHODS USED AND CHOOSE FROM THE ASSOCIATED DROP DOWNS FOR EACH SELECTED METHOD OR ENTER CORRESPONDING TEXT.

Sample: **Total residents:** TOTAL # OF RESIDENTS IN THE PROVIDER SETTING CENSUS AT THE TIME OF THE INVESTIGATION.

Resident sample size: TOTAL # OF CURRENT RESIDENTS REVIEWED, OBSERVED, OR INTERVIEWED AS PART OF THE INVESTIGATIVE SAMPLE

Closed records sample size: TOTAL # OF CLOSED RECORDS REVIEWED

Observations: PEOPLE/THINGS THE INVESTIGATOR SAW, HEARD, OR SMELLED DURING THE INVESTIGATIVE PROCESS. THIS MAY INCLUDE, BUT IS NOT LIMITED TO: WATCHING CARE, MEAL SERVICE, MEDICATION ASSISTANCE, CALL LIGHT RESPONSE, STAFF INTERACTIONS WITH RESIDENTS, RESIDENT APPEARANCE, ACTIVITIES, AND ENVIRONMENT (CLEANLINESS, ODORS, NOISE).

Interviews: PEOPLE THE INVESTIGATOR TALKED TO WHILE OBTAINING INFORMATION. WHEN RECORDING INTERVIEWS ON THE ISR THE INVESTIGATOR WILL NOT USE TITLES.

EXAMPLES FOR APPROPRIATE DESCRIPTORS OF INDIVIDUALS INTERVIEWED INCLUDE BUT ARE NOT LIMITED TO: NAMED RESIDENT, OTHER RESIDENTS, NURSING STAFF, FACILITY STAFF, PHYSICIAN, CASE-MANAGER, AND HOSPITAL STAFF. FOR OTHERS NOT IN THE CATEGORIES LISTED ABOVE, INVESTIGATORS MAY USE: OTHERS NOT ASSOCIATED WITH THE FACILITY OR COLLATERAL CONTACT.

Record Reviews: RECORDS THE INVESTIGATOR REVIEWED, WHICH MAY INCLUDE THE RECORD OF THE NAMED RESIDENT, RECORDS OF OTHER RESIDENTS, MEDICATION RECORDS, STAFFING SCHEDULES, MENUS, AND RECORDS FROM THE OUTSIDE FACILITY SUCH AS HOSPITAL RECORDS.

Investigation Summary: A BRIEF STATEMENT TO WHAT THE INVESTIGATOR FOUND AFTER INVESTIGATING EACH NUMBERED ALLEGATION. IF THERE IS MORE THAN ONE ALLEGATION, THE SUMMARY SHOULD BE SEQUENTIALLY NUMBERED AND CORRELATE WITH EACH SEPARATE ALLEGATION LISTED IN THE ALLEGATION(S) BOX ABOVE. STATEMENTS ARE BASED ON THE INVESTIGATOR'S ANALYSIS AND SUMMARIZATION OF FINDINGS. ANALYSES WILL INCLUDE CONCISE FACTS THAT ARTICULATE WHAT THE INVESTIGATOR OBSERVED AND WHAT THE FACILITY DID OR DID NOT DO IN RELATIONSHIP TO THE ALLEGED ISSUE(S). INDICATE IF FAILED PRACTICE WAS OR WAS NOT IDENTIFIED FOR EACH ALLEGATION.

Conclusion / Action THIS SECTION AUTO FILLED BY STARS

☐ Failed Provider Practice Identified / Citation(s) Written

☐ Failed Provider Practice Not Identified / No Citation Written

☐ N/A

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E. Examples

Public Complainant Contact Documentation

General example of documenting investigation initiation when intake received while already on-site:

> [Date][Time] Public complainant not called prior to investigation initiation as investigator was already on-site when received.

General example of documenting investigation initiation when response time interferes with completing 3 PC contacts:

> [Date][Time] Public complainant not called 3 times prior to investigation initiation due to response timeline.

Contacting relatives of a recently deceased AV

This section applies to situations where a resident has passed unexpectedly without concerns related to abuse or neglect in the intake.

General script to guide introduction to interview with resident representative:

> Hi, this is [Name] calling from Residential Care Services. I'm calling because we were notified that [Resident] passed away on [Date]. I'm so sorry for your loss. We check in with families to see how they felt about the care their loved one received at [Provider]. Is there anything you'd like to share about your experience?

Observations

Example observations of residents:

1. Appearance, hygiene, apparel
2. Demeanor (i.e., behaviors, mood, whether they appear comfortable, relaxed, happy)
3. Cognitive status and communication capabilities
4. Mobility (i.e., limitations/adaptive devices)
5. Presence of IVs, feeding tubes, catheters, splints, bruises, bandages
6. Injured/affected areas of vulnerable adult's body (ask the vulnerable adult permission to observe as they have the right to refuse).
7. Presence of restraining devices, safety (or medical) devices or practices
8. Interactions between staff and other vulnerable adults
9. Vulnerable adult's room:
    a. Is it homelike?

   b. Does the resident have access to personal belongings in reflection of their history and/or preferences?
   c. Clear pathways?
   d. Safety issues with cooking appliances?
   e. Quality of life concerns?
10. Is the vulnerable adult isolated or secluded?
    a. Door closed?
    b. Meals in room?
    c. Vulnerable adult in controlled access unit?

Example observations of Staff:

1. Interactions with vulnerable adults and other staff.
   a. Were staff respectful of vulnerable adult privacy, dignity, and independence?
2. Interventions and assistance provided to vulnerable adults
3. Provide redirection and cuing to vulnerable adults as needed?
4. Adequate supervision and staffing?
5. Techniques and skills?

Example observations of the Provider Environment:

1. Atmosphere:
   a. Welcoming
   b. Homelike vs. Institutional
2. Environment:
   a. Odors
   b. Cleanliness
   c. Lighting
   d. Temperature
   e. Safety hazards both inside/outside
   f. Restricted or blocked egress
   g. Clear pathways
   h. Pets
   i. Uneven surfaces
   j. Screens
   k. Pests
   l. Oxygen storage
   m. Signage

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3. Accommodation:
    a. Accessible phones
    b. Lowered sinks
    c. Bedside commodes
    d. Adaptive equipment and/or utensils

Interviews

All questions will be asked in a manner that does not disclose the allegation. CIs will consider their interview technique when planning and conducting an interview. Begin the interview with general/ open ended questions, narrowing in on the details as the interview continues.

General example questions to consider using with applicable interviewees:

1. Are you aware of the reported issue(s)? (Do not disclose the actual allegation but speak in general terms.)
2. How has this issue affected the vulnerable adult(s)?
3. How did you become aware of the problem?
4. How long has it been going on?
5. Have you told anyone?
6. Is the provider aware?
7. What was the provider's response?
8. What has the provider done about it?
9. Has the problem been resolved?
10. Do you have any other questions/concerns?

Example questions to consider for the PC:

1. When and how often do you typically visit the provider?
2. What are your concerns?
3. How did you become aware of the issue(s)?
4. When did it happen? Has it happened before?
5. Did you tell anyone? If so, whom?
6. Does the provider know about this concern?
7. Has anything been done about it?
8. Is it still a problem?
9. How did it affect the vulnerable adult?
10. Is the vulnerable adult able to describe what happened or identify the AP?
11. Do you know the name of the AP?

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12. If not, who could provide additional information?
13. Have other vulnerable adults been affected?
14. Is there a particular staff member or other vulnerable adult/family member/visitor you are concerned about?
15. When might that person be on duty or in the facility/home/provider?
16. Are there any other concerns?

Examples of general questions for the residents:

1. How long have you lived here?
2. How do you feel about living here?
3. How are you treated?
4. Who takes care of your needs?
5. What do they do for you?
6. Do staff give you the assistance you require for your condition?
7. Do staff come when you call?
8. How do staff and other vulnerable adults talk to you or treat you?

Examples of questions for the residents related to reported concerns:

1. I heard this happened. Tell me about it… (who, what, where, when)
2. How did it make you feel? How did it affect you? Ask for specifics that describe or explain what type of outcome they had (i.e., "It made me nervous", "I couldn't sleep for a week")
3. Has this happened before? (when, where etc.)

Examples of questions for the residents related to quality-of-life and/or vulnerable adult rights:

1. Are there rules related to living here? (i.e., bedtimes, mealtimes, visitors, etc.)
2. How do you spend your time? Is that satisfactory to you?
3. If dissatisfaction, boredom, fears, etc. are expressed, ask specifically what happened to make them feel that way.
4. Do you have any concerns about living here?

Examples of questions for the resident's family, representative or guardian:

1. How often are you in contact with the provider?
2. How recently have you been in the provider?
3. What have been your direct observations?
4. Do you still have concerns regarding care and services or other issues?

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Examples of questions for the provider staff:

1. What vulnerable adults have had issues/ reported concern/ had a change in condition? (Ask in a manner that avoids divulging the nature of the complaint)
2. What can you tell me about the resident's concerns?
3. How did you become aware of the problem?
4. When did it happen?
5. Has this ever happened before?
6. What have you done about it?
7. Is it still a problem?
8. What do you think may have caused it?
9. What process/ provider practice do you follow for concerns related to the reported concern or change of condition?
10. Who do you communicate with when the reported concern/ change of condition occurs?
11. How do you ensure staff are aware of changes in the vulnerable adult(s) care plan?
12. Can you show me your documentation?
13. Do you have concerns regarding care and services or other issues?

Record Reviews

Resident Related Record Review Considerations:

The CI will document the following information about vulnerable adult(s) included in the investigation, as applicable to the alleged issues:

1. Name
2. Date of Birth
3. Date of Admission
4. Pertinent diagnosis to the alleged issue
5. Designated Vulnerable Adult Representative Name and Telephone Number
6. Vulnerable Adult Room Number as applicable
7. Care and service needs with related interventions for all sample residents
8. Risk factors
9. Cognitive ability
10. Psychosocial or behavioral status
11. Communication ability
12. Transfer and mobility status
13. Activities of Daily Living (ADL) needs
14. Dietary needs

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15. Medications
16. Review any recent changes in medical, mental, physical, behavioral conditions, and/or medications
17. History of related incidents and/or occurrences
18. Other contributing factors

The CI will document the following supporting information (pertinent to alleged issues):

1. Documentation related to alleged incident and/or occurrence.
2. Pertinent assessments occurring before and after the incident, if applicable.
3. Pertinent interventions the provider put into place before and after the incident.
4. Determine whether the provider re-evaluated the vulnerable adult after the event and/or if new interventions were put into place.
5. Determine if appropriate notifications occurred.
6. For significant changes:
    a. Was a re-assessment done?
    b. Was it done timely?
    c. Was the re-assessment done by a qualified party?
    d. Were interventions implemented?
    e. Were appropriate parties notified?

Provider Related Record Review Considerations:

The CI will consider reviewing the following sources of provider information, as applicable to the alleged issue(s):

1. Evidence of provider investigation
2. Disclosure of Services
3. Admission Agreements
4. Policies and Procedures
5. Disclosure of Services
6. Disclosure of charges

Staff Related Record Review Considerations:

The CI will consider reviewing the following staff personnel information, as applicable to the alleged issue(s):

1. Name(s)
2. Date of hire
3. References (obtained and follow up with as applicable)
4. Current background checks with disclaimer and no disqualifying convictions

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5. Qualifications:
   a. Orientation to facility
   b. Specialty training (DDA/MH/Dementia)
   c. Current CPR and First Aid Certificate
   d. TB results
   e. HIV/AIDS
   f. Food Handler's card
   g. Basic/Modified Fundamentals
6. Current license or certification (if applicable)
7. Continuing education (pertinent training)
8. Evaluations/counseling for similar incidents
9. Nurse delegated training certificates (for tasks pertinent to reported concerns)

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F. Unlicensed or Uncertified Facilities

Review the following for Unlicensed or Uncertified facilities:

1. Consult with ALTSA divisions (including APS, RCS, and HCS), if appropriate, to see if they have any information associated with the reported provider's address.
2. Consult with your FM to determine whether the setting requires an RCS license/certification.
3. Plan to obtain key information about the facility/home/provider and its function during your investigation.

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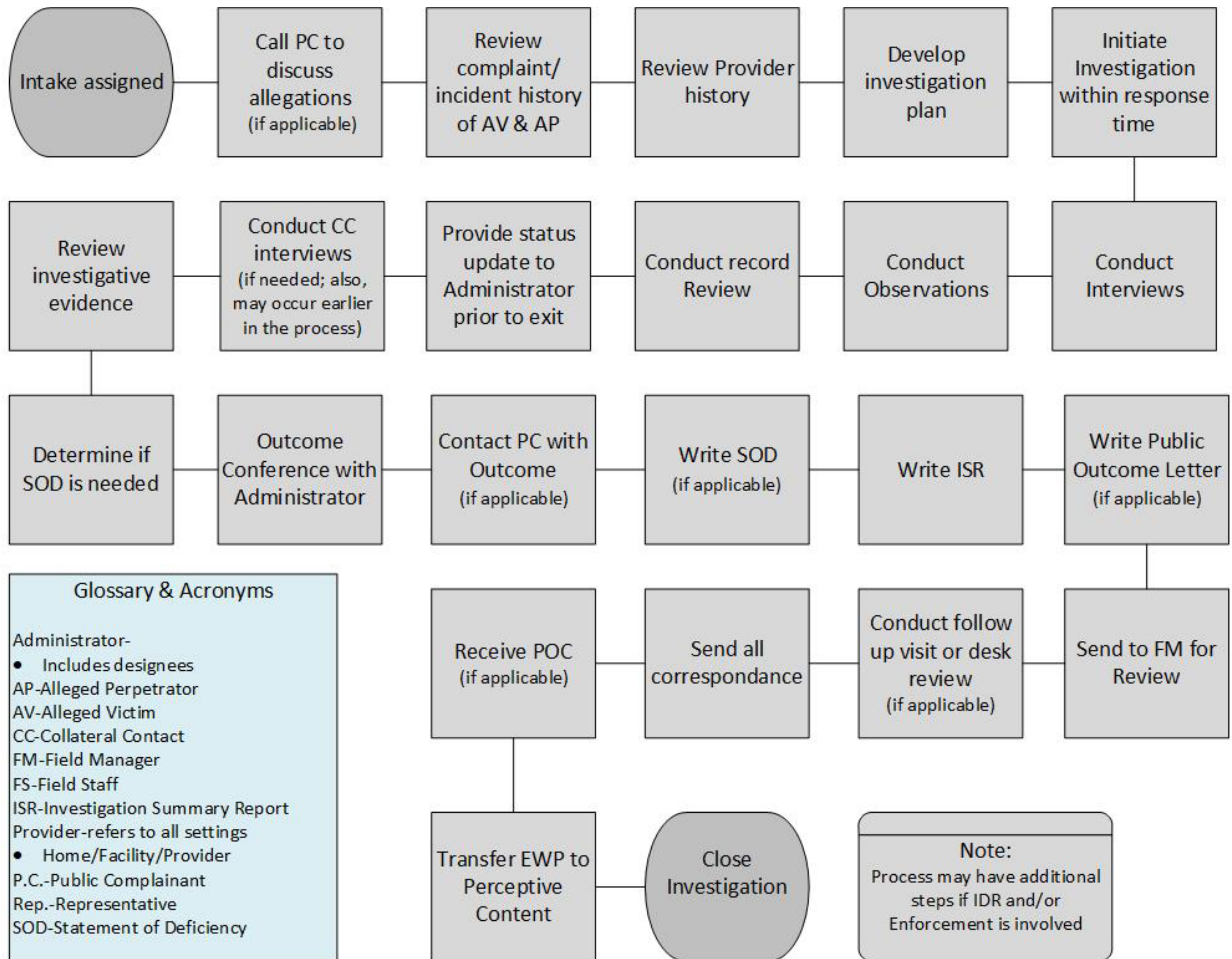
G. Complaint Investigation Process Map



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H. Complaint Investigation Pathways

Below are links to pathways into various allegation types within the identified setting.

Adult Family Homes

Assisted Living Facilities

Nursing Home Protocols

I. Rescinded Procedures

This Complaint Investigation SOP will supersede all other versions of the following complaint investigation procedures/guidelines including the following:

- 2004 RCS Operational Principles and Procedures for Communications in the Complaint/Incident Investigation; MB#R04-052
- 2007 Complaint Investigation (C/I) Guidance Manual; MB# R07-008
- 2007 Release of Final AFH & BH Complaint/Incident Investigation Protocols; MB#R07-027
- 2007 CRU Complaint/Incident Referral processing, MB# R13-031
- 2008 Complaint/Incident (C/I) Investigative Protocols, MB# R08-033
- 2008 NH Final Complaint/Incident Investigation Protocols 1-13, MB# R08-045
- 2008 Use of Key Triggers Reference Documents with NH Protocols, MB# R046
- 2008 RCS Operational Principles and Procedures for the Resident and Client Protection Program (RCPP)
- 2010 Operational Procedure for Complaint/Incident Resolution in ICF/IID
- 2010 Residential Habilitation Centers ICFs/MR only Reporting and Investigating Guidelines
- 2010 Operational Procedure for Complaint/Incident Resolution in Licensed LTC Residential Facilities
- 2011 RCS Operational Principles and Procedures for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) Complaint/Incident Resolution
- 2015 RCS Standard Operating Procedures 2-Day and 10 Day Complaint Investigation Management (Field Operations); MB# R11-031
- 2013 CRU Complaint/Incident Referral Processing, MB# R13-031
- 2015 RCS Standard Operating Procedures Complaint/Investigation in Licensed/Certified LTC Facilities/Settings (Field Operations); MB# R15-002
- 2016 Revisions to Standard Operating Procedure (SOP) for Complaint Investigations SOP for All Settings, MB# R16-025
- 2016 SOP: Revisions to Writing Complaint Investigation Summary Reports (ISR), MB #R16-052
- Any other associated policies, procedures, or protocols in existence for complaint investigations dated prior to this SOP.

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J. Change Log

Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
10.03.2023	Part III, Section D ISR Details	Updated ISR example	Updated to reflect current processes	10/03/2023 Support Call
04.20.2023	Part I, Section D Statements of Deficiency	Clarified timelines for federal programs	Clarify language for field staff	MB R23-025
04.07.2023	Glossary	Clarified definitions for reporter and complainant	To provide clarification for field staff	MB issued R22-068
03.20.2023	Complete chapter	Reformatting of entire chapter, with updated guidance to every section to provide clarity	To address persistent confusion	MB R23-025 Presentation on All RCS Staff Support Call in February 2023
9.15.2022 9.29.2022	Complete chapter	• Clarification of when and how to distribute VASOR. • Clarify referral protocol to APS if the investigator has reason to believe abuse, abandonment, financial exploitation, or neglect has occurred and a referral was not previously made. • Reorganization and editing.	To address persistent confusion about distributing the VASOR. To address potential gap in coordination with APS.	Presentation on All RCS Staff Support Call in October 2022 MB issued R22-068 Amended R20-085
2.11.2021	• 20A Complaint Investigations-All Settings	• IIA- Offsite Preparation, section (1)(b) Attempts to contact the public complainant	In relation to a PIP for Nursing Homes and Assisted Living Facilities. Clarification requested.	Posted on document review for 20 days

Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
		• IIF- Planning and Investigative Reviews- Reference to state for abuse • IVC- Onsite Activities, section (6) Added corrected references as above; on VASOR matrix 'Time' changed to 'Date' • V(B)- Offsite Activities- Documenting the outcome of the exit interview		Announced in Community Call February 1st, 2021 Documented in the 2020 PIP Plan MB issued R21-016
2.11.2020	• 20A4 Use of Photography	Update permissive use of state cell phone	To support cell phone use & the integrity of photo for retention	MB issued R20-011 Announce in Newsletter
8.16.2019	• 20A Complaint Investigations • 20B Writing ISR	Complete rewrite of sections for full inspection process for all settings, and minor formatting to other sections.	Incomplete directives on inspection, and updates on ISR.	MB issued: R19-057 Announce in RCS newsletter
11.2017	Page 20	Per PTQA Office Chief, removed #9 referencing use of cell phones & photography	Workgroup to review, determine next steps	TBD
9.2017	• 20A6 Coordination with APS	Coordination with APS added	Workgroup product	MB issued R17-049
5.2016	• 20A2 Writing ISRs	Last update prior to conversion to chapter format.		Posted on-line for employee review Announced in Weekly Update

Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
				MB issued: R16-052
4.2016	• 20A4 Use of Photography	SOP language updated from 2010 version and converted into chapter format SOP changed to include all settings	SOP format changed SOPs consolidated to cover all settings so updates can be tracked.	Posted on-line for employee review. MB issued: R16-027
3.2016	• 20A1 Offsite Preparation	Last update prior to conversion to chapter format.	SOP was for multiple settings. One SOP developed for all settings to ensure consistency.	Posted on-line for employee review. Announced in Weekly Update MB issued: R16-025
7.2014	• 20A3 Accessing Complaint Information in TIVA	Last update prior to conversion to chapter format.		
	• 20A5 Reporting Criminal Neglect	Last update prior to conversion to chapter format.		
2.2007	• 20A6 Protection of Resident Privacy and Data Security	Last update prior to conversion to chapter format.		

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