

# CHAPTER 20: Complaint Investigations



## Overview

Residential Care Services (RCS) has the 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 (SOP) provides guidance for consistent practices within 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 (also known as an abbreviated regulatory process) 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 course of 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 steps to complete in the course of an investigation
- Making a final determination at the conclusion of the investigation
- How to write reports and issue them within the required timelines
- How to close a complaint

### For the purposes of this chapter:

- ‘Provider’ or ‘entity’ in this document will refer to adult family homes (**AFH**), assisted living facilities (**ALF**), certified community residential services and supports (**CCRSS**), enhanced services facilities (**ESF**), intermediate care facilities for individuals with intellectual disabilities (**ICF/IID**), and nursing homes (**NH**).
- ‘Resident’ refers to residents (**AFH, ALF, ESF and NH**) or clients (**CCRSS and ICF/IID** settings). In this chapter, the term ‘resident’ will be used for all settings.

The  icon indicates information that is of specific importance to staff that may require additional attention (i.e., documentation requirements, etc.).

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

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

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## Field Manager Responsibility

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

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

## Contacts

- [RCS Quality Improvement Unit General Contact](#)
- [RCS Policy Unit General Contact](#) (**internal** RCS use)
- [RCSPolicy@dshs.wa.gov](mailto:RCSPolicy@dshs.wa.gov) (**external** RCS use)
- [RCS Training Unit General Contact](#)



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## Part I: Complaint Investigations – All Settings


### A. Investigation Preparation

#### 1. Assignment and Review of the Intake

- a. The unit Administrative Assistant (AA) will:
  - 1) Assign complaint intakes received from the Complaint Resolution Unit (CRU) to a Complaint Investigator for investigation, including any additional pertinent instructions or relevant information.
- b. The Complaint Investigator (CI) will (in collaboration with the Field Manager [FM] if needed):
  - 1) Review the following information in the Secure Tracking and Reporting System (STARS):
    - a) The priority assignment.

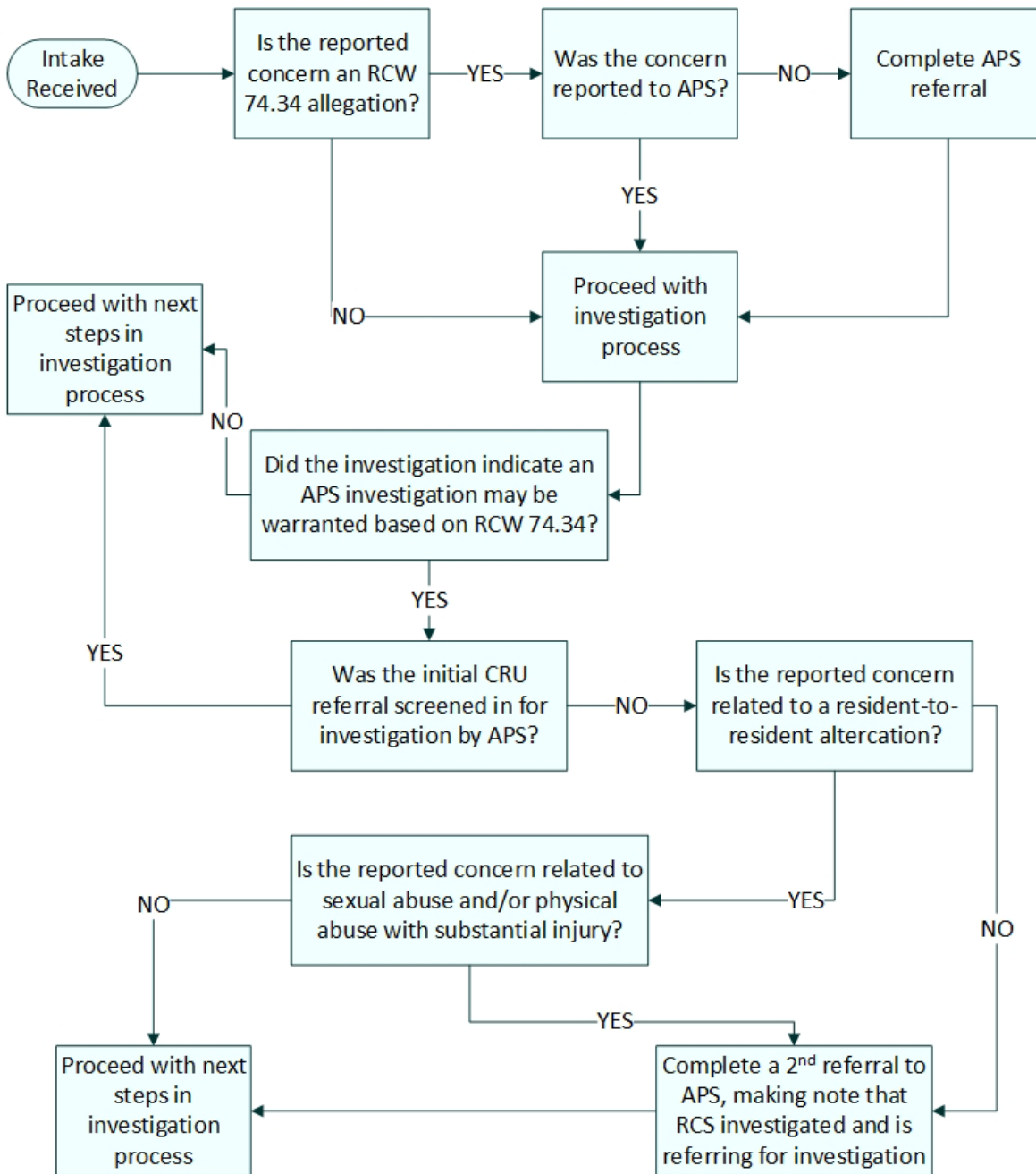
Note: Any changes to assigned priority must follow [RCS SOP Manual Chapter 4 – CRU](#).

- b) CRU referrals made at the point of intake to other agencies and services.

 Note: All referrals made to Adult Protective Services (APS) that do not involve **sexual or physical abuse** (or physical abuse with substantial injuries if related to a resident-to-resident altercation) will not be investigated by APS unless the RCS CI determines during investigation that APS involvement is warranted. In those instances, the CI will be required to submit a second referral that includes details of why APS involvement may be warranted. See [decision tree](#) on the following page.

- c) Any preliminary issues related to the allegation(s) (i.e., safety concerns, coordination needed with other investigative agencies, etc.).

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Acronyms
APS – Adult Protective Services
RCS – Residential Care Services
RCW – Revised Code of WA

**APS Referral Decision Tree**

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## 2. Reviewing the Provider and Resident History

The CI will review the following for the alleged victim (AV), alleged perpetrator (AP) and entity:

- a. Relevant complaints within the last year, noting any similar issues or trends. The timeframe can be expanded if there are identified concerns (up to 36 months for **AFH**, **ALF**, and **ESF**, up to 24 months for **CCRSS**).
- b. Tracking systems, as applicable (i.e., STARS, ASPEN, FMS, and CARE).
- c. Entity status, as applicable:
  - 1) License/certification number and number of residents for which the provider is licensed.
  - 2) Current state contracts and/or any specialty designations (i.e., dementia, mental health, and/or developmental disabilities care).

Note: RCS does not regulate or monitor contracts. The purpose of reviewing contracts is to determine if there are relevant WAC requirements that may require compliance (e.g., EARC in **ALF**).

- 3) Most recent licensing or certification visit findings, noting any uncorrected deficiencies.
  - a) If the provider is out of compliance, consider consulting with the FM as appropriate about coordinating the complaint initiation, while being mindful of any needed follow up visits for previously cited deficiencies.
- 4) Enforcement history including any conditions on the license/certification since the last full inspection, noting any trends and/or current enforcement actions.
- 5) Exemptions, waivers, and/or exceptions.
- 6) Recent changes of ownership (CHOW) and/or changes of management (CHOM).


Note: For Unlicensed or Uncertified facilities or Unpaid Licensing Fees, please refer to the appendices and/or the Pathways (See [Resources](#) for more information).

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## 3. Public Complainant (PC) Interview

a. The CI will:

- 1)  Make a minimum of three attempts to reach the PC prior to initiating the investigation on-site. All attempts must be documented in the electronic working papers (EWP). Documentation must include the date and time of contact.
  - a) If the reporter is a LTC staff member, but is making the report as a whistle blower, they must be called as a public complainant.
- 2) The following situations are acceptable exceptions to contacting the PC prior to initiating the investigation on-site:
  - a) CI is on-site at the time the intake is received.
  - b) The PC has requested no call back.
  - c) PC resides under the care of the provider and will be interviewed on-site.
  - d) The intake report indicates another individual is the source of the report (e.g., a hospital SW files a report based on concerns given to them from a family member).
    - If that is the situation, call the source of the report in lieu of the PC named on the report.
  - e) The reporter is anonymous and has left no contact information.
- 3) The following situations are acceptable reasons to not complete *all three* contacts prior to initiating the investigation on-site. If any of the following reasons apply, the CI must obtain approval from their FM by requesting supervisor review through the EWP.

Note: this does not negate the requirement for contacting the PC, only the need for *three* attempts prior to investigation initiation.

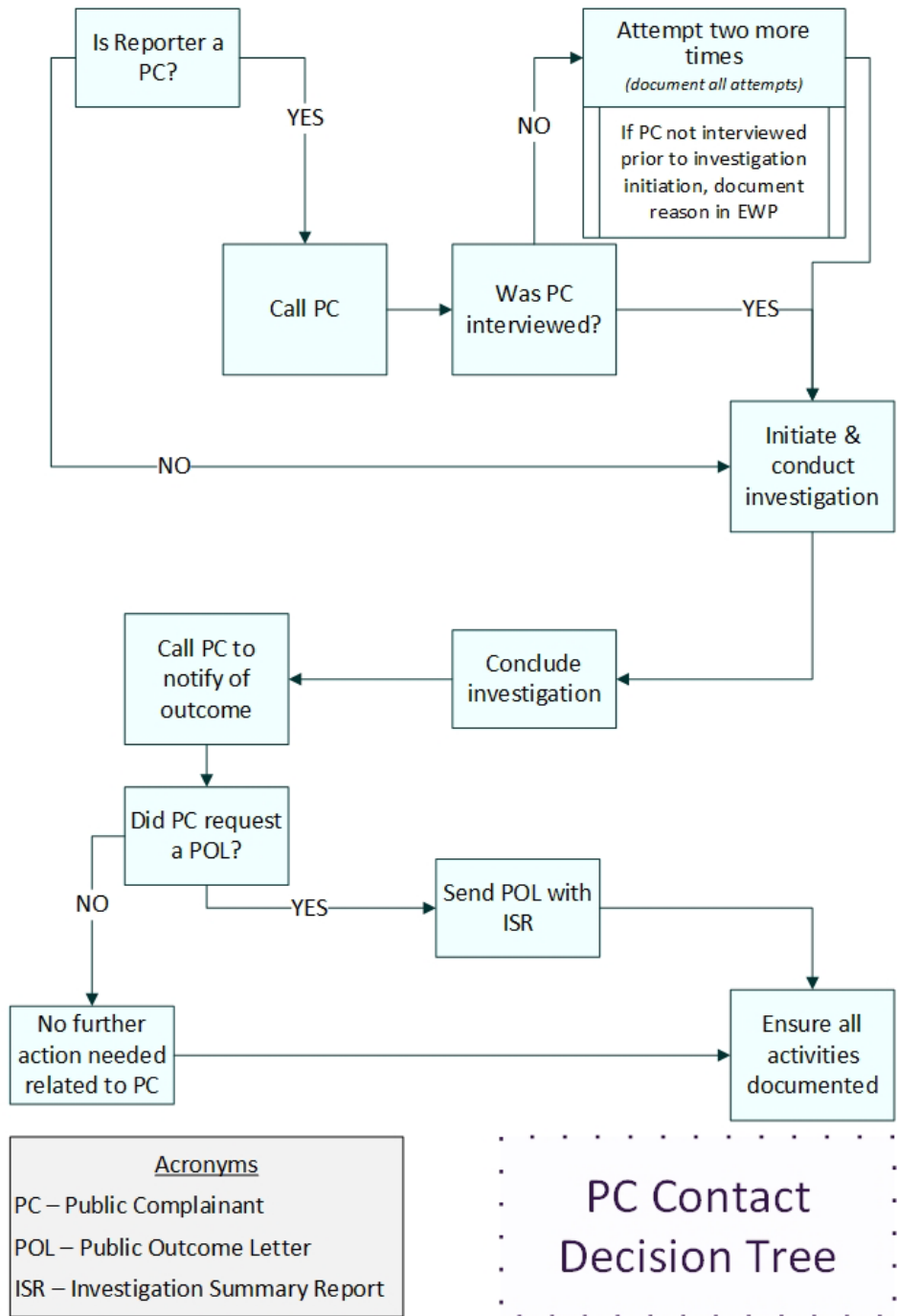
- a) The nature of the report requires urgent initiation of the on-site visit
    - Potential for imminent harm
    - Potential for loss of evidence
  - b) Travel
  - c) Reporter is a first responder or hospital employee
  - d) Contact phone number is disconnected
  - e) CI workload precludes interview being conducted prior to initiating on-site
- 4) If the above-mentioned circumstances do not apply, the CI must consult with the Field Manager (FM) about any additional situations where the PC will not be contacted and obtain approval by requesting supervisor review through the EWP.

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- 5) If, when interviewing a PC, they voice concern about their identity being disclosed, explain confidentiality will be respected, and their name would only be disclosed as required by law.
  - a) Explain that 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.

See [Appendix E](#) for examples of documentation related to PC contacts.



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## 4. Contacting the Ombuds – NH Only

Prior to initiating the on-site investigation, the CI will contact the Ombuds to discuss the nature of the complaint and whether there have been any similar complaints reported to and substantiated by the Ombudsman. The complaint investigation should not be delayed pending response from the Ombuds. A list of all the Ombuds' contact information may be found [here](#).

### Complaint intakes with a 2-day priority response:

The NH complaint investigator will contact the Ombuds via telephone to gather relevant information related to the reported concern.

### Complaint intakes with a 10-day, 20-day, or 45-day priority response:

The NH complaint investigation will contact the Ombuds via email to gather relevant information related to the reported concern.

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## 5. Developing an Investigation Plan

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

- a. Identified regulations and/or care areas related to the allegations and/or potential failed practice.
- b. Determine if coordination needs to occur with other investigative entities (i.e., Law Enforcement [LE], Adult Protective Services [APS], Department of Health [DOH], etc.) prior to conducting any on-site investigation.
- c. Identify possible observations, and/or record reviews, based the allegation(s) and/or potential failed practice.
- d. Develop focused questions based on the allegation(s) and/or potential failed practice.
- e. Plan when the on-site visit 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 Alleged Perpetrator [AP] may be working, when there might be inadequate staffing, etc.).

See the [Pathways](#) for examples of plans for specific allegation types (including observations to collect, persons to interview, questions to ask, etc.).

### a. Observations

Observations are the most powerful evidence investigators collect, especially when validated by interviews and record reviews. Prior to completing formal 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, conducting informal observations throughout the visit.
- 2) Obtain a copy of the resident census and names of staff on duty, if applicable.
- 3) Determine if any additional RCS staff need to accompany the CI when conducting observations. (e.g., only a licensed nurse may complete observations of a resident's breasts, buttocks, and genitalia).
  - a) If a nurse is not available, consult with your FM to determine how to proceed.

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


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## b. Interviews

Note: [RCW 74.34.067](#) and [SOM 5300.3](#) require the Department (State Agency [SA]) to conduct interviews with the Public Complainant (PC) and the Alleged Victim (AV). This means the Department must not rely on interviews conducted as part of an entity's internal investigation. In the NH program, RCS is conducting a Facility Reported Incident (FRI) Pilot. Refer to [MB R25-035](#) for more information, including the process RCS uses to conduct FRI administrative/off-site investigations.

The CI must:

- 1)  Interview all named AVs whenever possible. This includes AVs who are no longer a resident. If that AV is unable to be interviewed, a representative must be interviewed on the AVs behalf.

Note: If there is a need to protect the identity of the AV, consider interviewing other residents not named in the intake.

- a) 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.
- b) If there is a compelling reason to not complete an interview with a named AV, the CI must consult with the FM about any situations where the AV or their representative will not be contacted and document the reason and obtain approval from the FM by requesting supervisor review in the EWP.
- 2)  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 (e.g., phone call, email, etc.) in the EWP.
  - a) If the reported concern does not involve a resident (e.g., unpaid licensing fees), then an AV interview is not required. The CI may want to consider completing resident interviews based on the nature of the concern, and information learned during the investigation process.

Note: If the reported concern involves **infection outbreak only** (i.e., influenza, pneumonia, norovirus, etc.) and does not allege any failure on the part of a provider or an individual (e.g., failure to use PPE, etc.), AV interviews are not required. The CI may want to consider completing AV interviews based on the nature of the concern, and information learned during the investigation process.

- 3) Let the AV lead the interview by allowing them to ask questions or provide any information they deem relevant.
  - a) Use open-ended questions and active listening skills
  - b) Speak slowly and clearly.
  - c) Clarify any statements that are unclear or need further explanation.

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**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 EWP. This interview does not remove the requirement to complete the [Exit Conference](#) with the Administrator.

When determining who needs to be interviewed, consider the following individuals:

- Alleged victims (AVs)
- Other residents
- Provider’s staff
- Veteran’s Administration (VA) personnel
- Healthcare staff
- Activity center staff or coordinators
- Ombuds
- Alleged perpetrators (APs)
- Legal representatives or family
- Visitors
- Nurse delegators
- Law Enforcement
- Social clubs
- Other department or agency staff (HCS/DDCS/MH/APS case managers)

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:

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

## c. 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 (e.g., information may be found on data sheets, face sheets, etc.) in the corresponding field in the EWP.

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Note: If records need to be requested, CIs may use the optional [Complaint Investigation Request for Documents](#) form.

When determining what records will be pertinent to the investigation, consider the following (this list are examples only, and records reviewed may extend beyond these items):

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

Note: Never take copies of the background and/or fingerprint check results from the facility or home. If non-compliance is found, document your related observations, interviews, and record reviews. Copies of background and/or fingerprint checks are not to be maintained in the working papers.

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## B. Infection Prevention and Control (IPC) Assessment – Community Programs Only (AFH, ALF, CCRSS, and ESF)

### Background

The 2020 COVID-19 public health emergency highlighted the importance of effective infection prevention and control (IPC) practices in long-term care (LTC) settings. The information provided in this section provides tools and guidance for evaluating IPC systems and practices in response to IPC-related complaints, helping ensure resident/client safety across LTC settings.

### Relevant Forms

#### AFH, ALF, ESF

[IPC Complaint Investigation Tool – AFH, ALF, ESF \(DSHS 13-941\)](#): Provides a checklist version of the form.

[IPC Complaint Investigation Pathway – AFH, ALF, ESF \(DSHS 13-940\)](#): Provides prompts and details to complete the IPC complaint investigation.

[IPC Complaint Investigation Notes – AFH, ALF, ESF \(DSHS 13-944\)](#): The Notes form does not replace the Tool or the Pathway. It is designed as a supplement when additional documentation is needed.

#### CCRSS

[IPC Complaint Investigation Tool – CCRSS \(DSHS 13-942\)](#): Provides a checklist version of the form.

[IPC Complaint Investigation Pathway – CCRSS \(DSHS 13-943\)](#): Provides prompts and details to complete the IPC complaint investigation.

[IPC Complaint Investigation Notes – CCRSS \(DSHS 13-945\)](#): The Notes form does not replace the Tool or the Pathway. It is designed as a supplement when additional documentation is needed.

### Procedure

When a complaint alleges an IPC-related issue, regulatory staff will begin the off-site preparation to gather data and determine next steps.

1. Review current nationally accepted IPC recommendations for standard and transmission-based precautions, provided by the Centers for Disease Control & Prevention, and any IPC-related rules, proclamations, ordinances, emergency declarations, or disease-specific guidance that may be in observance at the time of the allegation.
2. Off-site preparation will include the use of the Tool or Pathway Form designated for the specific setting.
  - a. Completion of the Tool *or* Pathway in its entirety is required for all IPC complaint investigations.

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- b. If multiple intakes are investigated during the same field visit, regulatory staff will add a statement in the EWP to indicate which file or electronic folder contains the ICP Tool or Pathway.

Example: The IPC Pathway is located with working papers for Intake 0000.

3. Review the Resource Links listed at the bottom of Tool or Pathway Forms.
4. Prepare to carry sufficient personal protective equipment (PPE) for any Transmission-Based Precaution (TBP) circumstances (airborne, contact, droplet).
5. Upon entering the setting, verify if there is any updated information on additional communicable diseases present.
  - a. If a communicable disease outbreak is present in the setting, consult the Field Manager as needed prior to initiating the investigation, and don appropriate PPE as directed or indicated.
6. The investigation will include documentation of IPC observations, interviews, and record reviews on the IPC forms and the forms will be added to the EWP.

### Field Manager Responsibility

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

1. Request training or clarification from regional administrators or the RCS infection prevention and control team as needed.

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### C. 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. Approval must be noted by requesting supervisor review in the EWP or by FM documentation in STARS.

CI's are responsible for securing all investigative documents, including electronic documents (e.g., documents stored on state issued laptops or cell phones) in accordance with [DSHS Administrative Policy Chapter 5 – DSHS Records and Privacy](#). When scanning documents, RCS staff must use portable scanners. State issued cell phones must not be used for scanning documents.

Note: The hardcopy of the CRU intake must never be taken out of the office at any time, as it contains information protected by law.

The CI must consider when it is necessary to provide the Vulnerable Adult Statement of Rights (VASOR) Form (See [Appendix D](#) for more information and decision tree). The VASOR is **required** to be provided to all named alleged victims (AVs) if the intake contains allegations of abandonment, abuse, financial exploitation, or neglect of a vulnerable adult per [RCW 74.34.305](#).

Note: In order to protect the named AV's identity, in **AFH** and **CCRSS** settings, consider whether a VASOR should be provided to all residents living in the same home at the same address.

1. Provide a brief explanation of the purpose of the VASOR (e.g., this explains you have the right to be safe and have your needs met).
  - a. If providing to the AV's representative by mail, send the document within 10 working days of the date of AV interview. Send with the [template cover letter](#). The VASOR is required to be provided to the AV's representative when the AV is unable to be interviewed, or the AV refuses to accept the form.
    - 1) If the AV is unavailable for interview, the VASOR may be left in their room.
  - b. The CI will notify the unit AA when a VASOR needs to be mailed to a representative.
  - c. Once sent, the unit AA will notify the CI via email. The CI will then document in the EWP the date the VASOR was sent.
    - 1) This may be accomplished by uploading a copy of the email.

For [Observations](#), [Interviews](#), and [Record Reviews](#), please see applicable sections.

The role of the CI is to determine whether deficient provider practice(s) has occurred related to the complaint. The CI will use data gathered during the investigation to determine findings.

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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. 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).
2. Whether RCS has regulatory authority for every issue in the complaint. Determine if referrals to other agencies are required.
3. Rules and regulations as they apply to the alleged issue and may support potentially identified deficient 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).
  - b. The deficient practice statement (DPS) within the Statement of Deficiency (SOD) must define what actions the entity did or did not take and include the data sources collected during the investigation process (see [SOP Chapter 18 - Across All Settings](#) and the Principles of Documentation for more information).
4. Determination of the scope and universe of the identified deficient practice(s). CIs have a responsibility to determine if the complaint is reflective of a pattern of behavior by selecting a representative sample (see the section labeled '[Sample Selection](#)' for more information).



## 1. Imminent Safety Concerns – Response During Investigation

The CI's role is to evaluate and assess the health and safety of residents in the setting, including identifying any immediate risks. If during an investigation it is determined the safety of any resident is at risk of harm the following must occur:

- a. Call 911 first, if an emergency.
- b. The CI will call the FM to determine what, if any, actions are necessary to resolve the immediate risk to resident health and safety.
- c. If a written safety plan is needed pending the investigation, the FM will:
  - 1) Contact the Compliance Specialist (CS) to determine if immediate enforcement action is needed to protect residents.
  - 2) Determine what actions on the part of the provider will resolve the immediate risk. Actions may include requesting for an alleged perpetrator (AP) to be removed from the setting.

Note: Safety Plans are not utilized in Federal Programs (**NH** and **ICF/IID**). Federal programs follow the Immediate Jeopardy (IJ) protocol.

- d. The CI will request the identified actions from the provider once determined by the FM.
- e. A report to the [Complaint Resolution Unit \(CRU\)](#) may be needed depending on the nature of the concern (see Filing a Complaint Intake from the Field in [SOP Chapter 18 – Across All Settings](#) for more information).

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## 2. Entrance

Upon contact with entity staff, the CI will:

- a. Provide their name, business card, and general purpose of their visit.
  - 1) Providing the FM’s number or a general contact number is acceptable.
  - 2) If the complaint was reported by the entity, it is acceptable to provide the details of which incident is being investigated.
  - 3) If the complaint was received from any other source, be more generalized about the purpose of the visit (i.e., investigating a complaint, checking on the health and safety of residents, etc.).
- b. Establish a courteous, respectful, objective, and neutral tone to encourage and facilitate communication.
  - 1) Briefly explain the investigative process, if necessary.
  - 2) If the administrator or designee is not present, the CI will request they be notified.

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.

Note: In a **CCRSS** setting, the CI must ask who is in charge and who all is in the home. If there are no staff on site upon arrival, immediately notify the FM, then call the service provider. Proceed with the investigation, including conducting observations and interviews. CIs do not need to wait for staff to arrive before proceeding



### 3. Sample Selection

#### a. AFH and CCRSS only

The CI will focus on selecting a sample of residents who are most likely to have conditions, needs, or problems described in the allegation (e.g., if the report is related to a fall, the CI may want to review all falls that occurred over the last 30-90 days).

Based on the population served in the setting, it may not always be possible to find a sample of residents with similar or the same care needs (e.g., even in large settings, you may have only one resident receiving dialysis services).

A sample may not be required when the allegation is related to the following:

- Fire marshal complaints
- Unpaid licensing fees
- Report is related to an unexpected death with no concerns related to abuse or neglect noted.

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 abuse or neglect (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.).

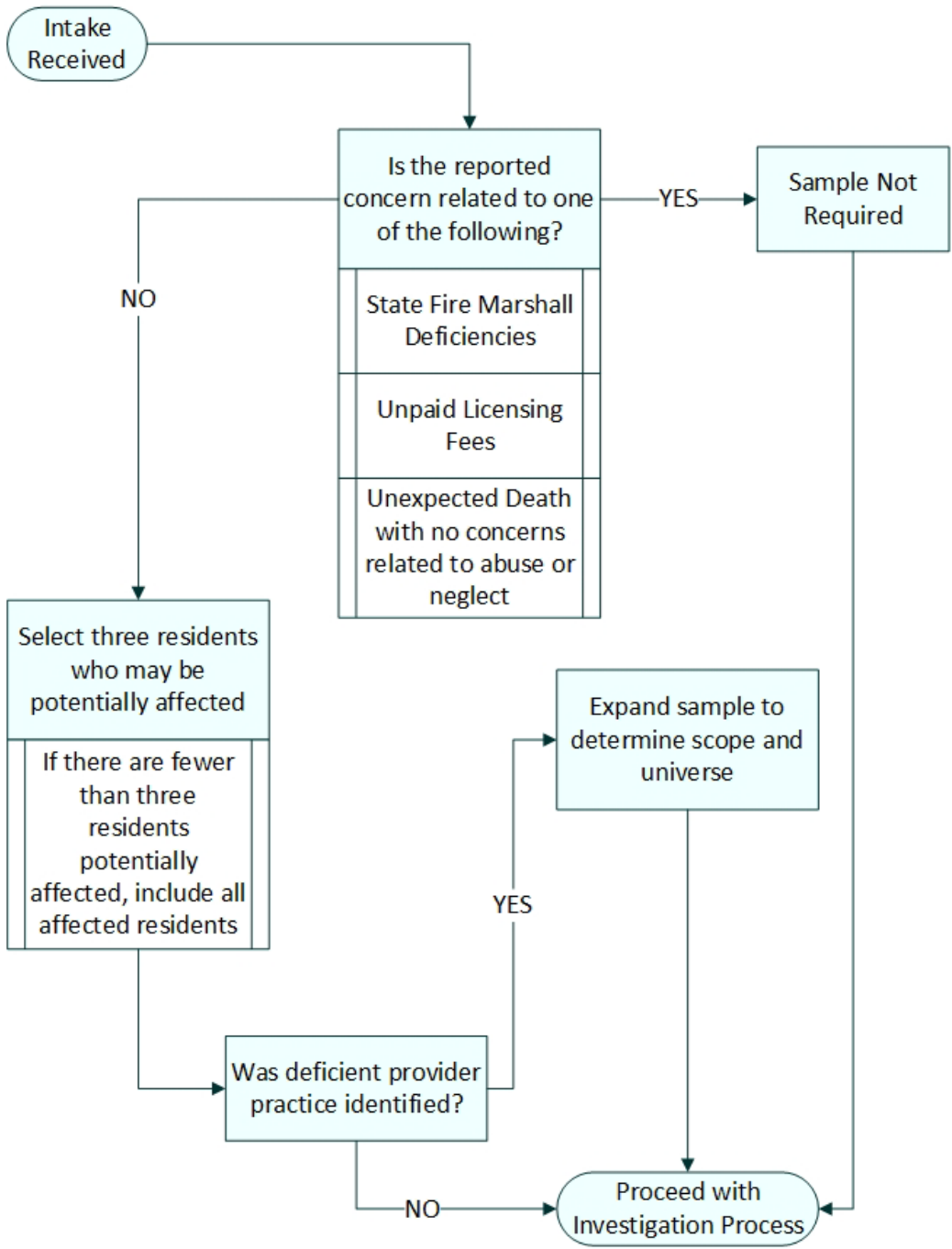
Note: In **CCRSS** settings, determine if other clients and/or homes need to be included in the sample. Only those clients and/or homes served under the same certification number can be included.

- 4) The sample size will vary depending on the situation, nature of the allegation, and the number of residents potentially affected.
  - Begin with a sample of three residents when possible. If there are fewer than three affected residents residing under the entity's care, the sample must include all affected residents. Sample may be expanded as needed.

 See Sample Selection Decision Tree on the following page.



## Sample Selection Decision Tree



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### b. ALF, ESF, ICF/IID and NH only

The CI will focus on selecting a sample of residents who are most likely to have conditions, needs, or problems described in the allegation (e.g., if the report is related to a fall, the CI may want to review all falls that occurred over the last 30-90 days).

Based on the population served in the setting, it may not always be possible to find a sample of residents with similar or the same care needs (e.g., even in large settings, you may have only one resident receiving dialysis services).

A sample may not be required when the allegation is related to the following:

- Fire marshal complaints
- Unpaid licensing fees
- Report is related to an unexpected death with no concerns related to abuse or neglect noted.

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 abuse or neglect (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.).

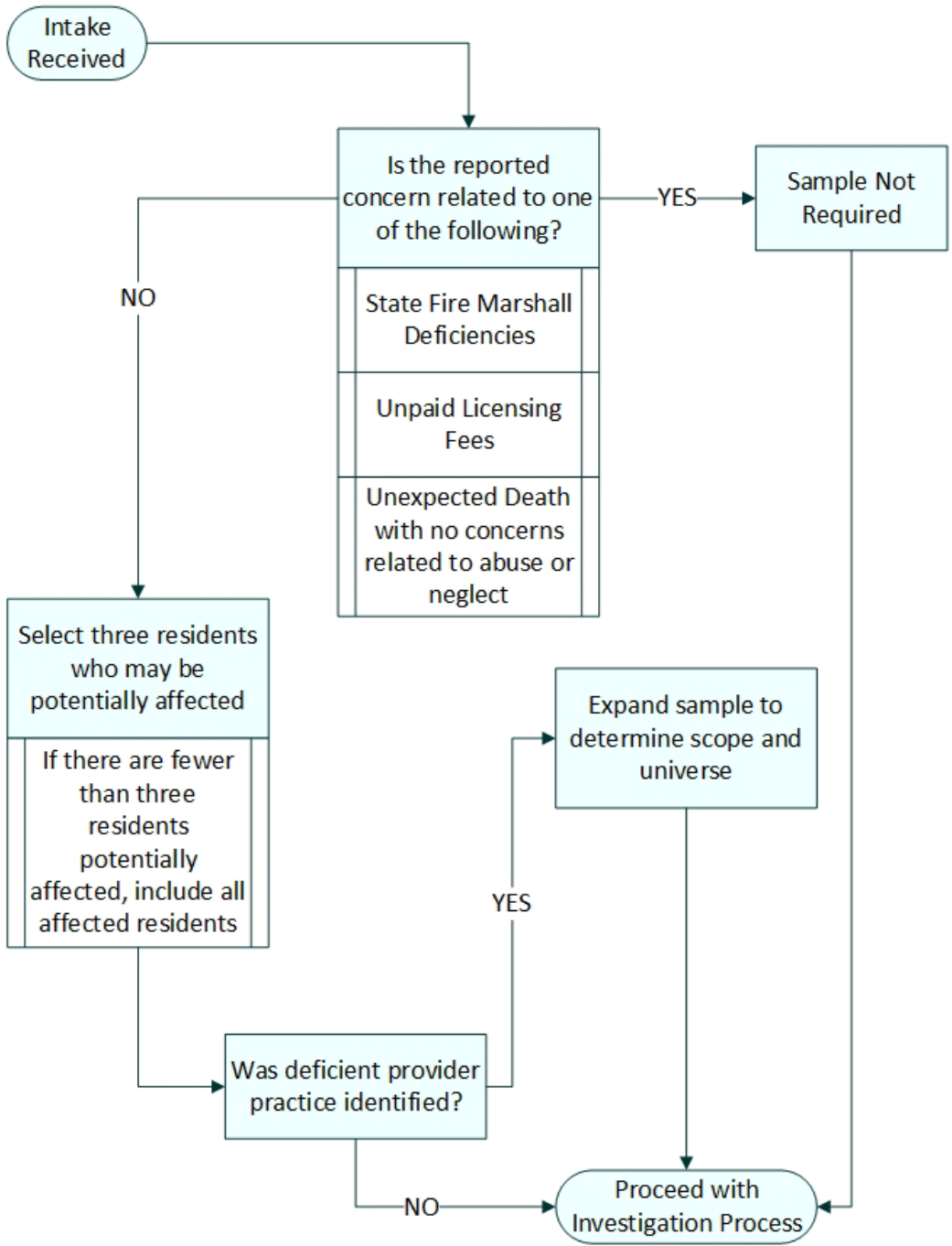
Note: In ICF/IID, determine if other clients and/or cottages need to be included in the sample.

- 4) The sample size will vary depending on the situation, nature of the allegation, and the number of residents potentially affected.
  - a) Begin with a sample of three residents when possible.
    - If there are fewer than three affected residents residing under the entity's care, the sample must include all affected residents.
  - b) Expand beyond three if deficient practice is identified, with the focus of determining how widespread the deficient practice may be.

 See Sample Selection Decision Tree on the following page.



## Sample Selection Decision Tree



# CHAPTER 20: Complaint Investigations



## 4. Data Analysis

During the process of investigation and data collection, the CI will evaluate findings as they relate to regulatory requirements. The CI will need to confirm the following:

- a. Findings are verified by a minimum of two data sources (i.e., observations, interviews, and/or record reviews).
- b. Conclusions have been tested for assumptions.
  - 1) If an assumption was made, determine what additional information might either validate or change the assumption.
- c. Verify the evidence gathered supports a preponderance of evidence in the determination of compliance.
  - 1) If a preponderance of evidence to support compliance cannot be made, determine what other facts or information could support a finding based on preponderance.

If the CI has determined a resident was harmed as a result of the allegations, the CI will consider the following:

- a. Whether the outcome was avoidable or preventable.
- b. Whether the provider recognized and addressed trends or patterns.
- c. Whether the provider responded timely, including protecting residents as necessary.
- d. Any systemic problems have been addressed.
- e. Whether the provider identified or should have identified the resident to be “at risk.”
  - 1) If so, whether the provider developed effective interventions addressing risk factors;
  - 2) Whether the provider implemented preventative measures consistently and as planned; and
  - 3) Whether the provider re-evaluated the effectiveness of preventative measures.
  - 4) If systems are in place to ensure provision of preventative measures (i.e., quality assurance programs, staff training, staff qualifications, investigations, supervision, etc.).

If an additional concern(s) is reported during the course of the investigation, the CI must report in accordance with the processes outlined in [SOP Chapter 18 – Across All Settings](#) in the section labeled ‘Filing a Complaint Intake from the Field.’

## CHAPTER 20: Complaint Investigations




### 5. Preliminary Exit Conference – AFH and CCRSS only

The preliminary exit conference (referred to as the “Oral Summation at Exit” in the EWP) occurs when the CI concludes the on-site investigation. This information may be shared with the provider in one of two fashions:

- a. While the CI is still on site; or
- b. Within 2 WD from last date on site.

The CI will review issues with the provider, including but not limited to:

- a. Preliminary findings and identified deficiencies. Preliminary findings may change if additional information affects the outcome of the investigation.
  - 1) Inform the provider if there is a possible need for further data collection.
  - 2) Inform the provider they will be contacted by telephone or email if any of the information provided during the preliminary exit conference changes (see section labeled ‘[Final Exit Conference](#)’ for more information).
- b. Ensure that the provider is aware of resident issues in need of immediate attention.
- c. Allow the provider an opportunity to discuss the investigation, ask questions, and present related additional information.
- d. Inform the provider of the Statement of Deficiencies (SOD) process, including:
  - 1) SOD will be sent within 10 working days from the last date of data collection (See section labeled ‘[Final Determination](#)’ for more information).
  - 2) Will include a cover letter explaining if a plan of correction (POC) and/or attestation is required.
  - 3) Provider requirement to send back a POC and/or attestation within 10 calendar days of SOD receipt.
  - 4) Informal Dispute Resolution (IDR) process.
- e. Present the provider with contact information for the FM. Inform the provider that the FM may be a resource for questions regarding the findings.
- f. Thank the provider for their cooperation with the investigation.

 The CI will document the preliminary exit conference, including any plans disclosed by the provider intended to ensure resident safety, in the EWP. Documentation must include at a minimum:

- Date;
- Time;
- Which individual the meeting was with, including their name and title; and
- The outcome relayed to the provider (whether deficient practice was or was not identified).

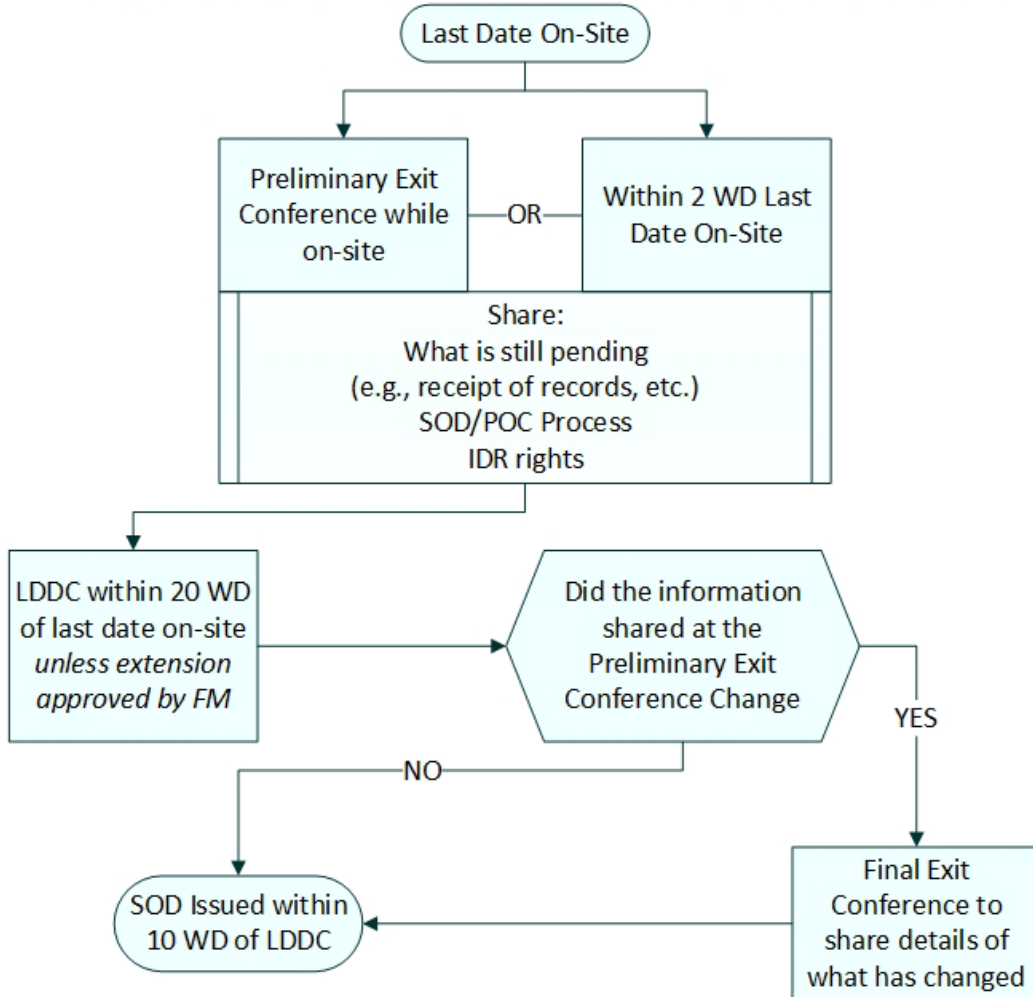
The preliminary exit conference must always occur, though it may occur prior to the last date of data collection. The final exit conference is only required if the information provided during the preliminary exit conference has changed.

See timeline example on the following page.

# CHAPTER 20: Complaint Investigations



## Exit Conference Timeline for Complaint Investigations (AFH and CCRSS Settings)



### Acronyms

- AFH – Adult Family Homes
- CCRSS – Certified Community Residential Services and Supports
- FM – Field Manager
- IDR – Informal Dispute Resolution
- LDDC – Last Date of Data Collection
- SOD – Statement of Deficiency
- POC – Plan of Correction (includes Attestations in this context)
- WD – Working Days


## CHAPTER 20: Complaint Investigations



### 6. Initial Exit Conference – ALF and ESF only

The initial exit conference (referred to as the “Oral Summation at Exit” in the EWP) occurs when the CI concludes the on-site investigation. The CI will review issues with the provider, including but not limited to:

- a. Initial findings and identified deficiencies. Initial findings may change if additional information affects the outcome of the investigation.
  - 1) Inform the provider if there is a possible need for further data collection.
  - 2) Inform the provider they will be contacted by telephone or email if any of the information provided during the initial exit changes (see section labeled ‘[Final Exit Conference](#)’ for more information).
- b. Ensure that the provider is aware of resident issues in need of immediate attention.
- c. Allow the provider an opportunity to discuss the investigation, ask questions, and present related additional information.
- d. Inform the provider of the Statement of Deficiencies (SOD) process, including:
  - 1) SOD will be sent within 10 working days from the last date of data collection (See section labeled ‘[Final Determination](#)’ for more information).
  - 2) Will include a cover letter explaining if a plan of correction (POC) and/or attestation is required.
  - 3) Provider requirement to send back a POC and/or attestation within:
    - a) 10 calendar days of SOD receipt for **ALF**; or
    - b) 10 working days (WD) of SOD receipt for **ESF**.
  - 4) Informal Dispute Resolution (IDR) process.
- e. Present the provider with contact information for the FM. Inform the provider that the FM may be a resource for questions regarding the findings.
- f. Thank the provider for their cooperation with the investigation.

 The CI will document the initial exit, including any plans disclosed by the provider intended to ensure resident safety, in the EWP. Documentation must include at a minimum:

- Date;
- Time;
- Which individual the meeting was with, including their name and title; and
- The outcome relayed to the provider (whether deficient practice was or was not identified).

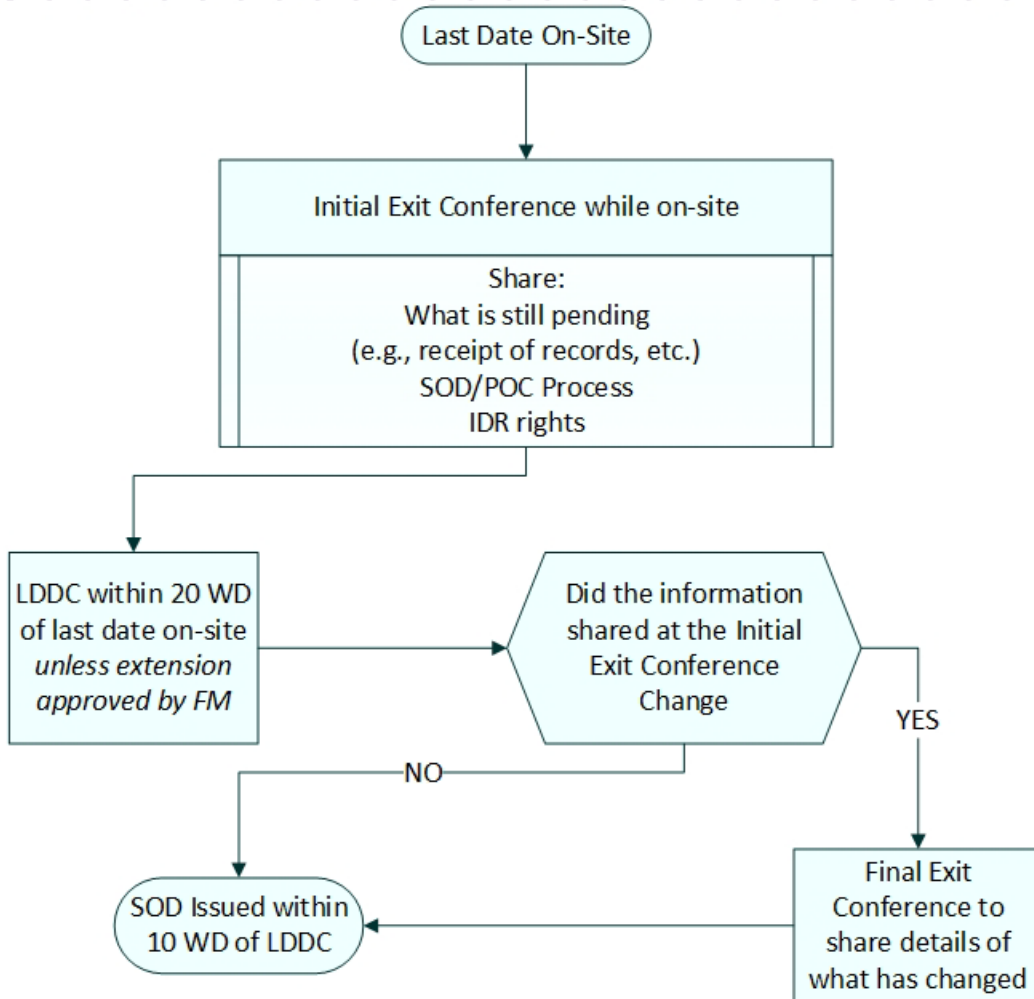
The initial exit must always occur, though it may occur prior to the last date of data collection. The final exit conference is only required if the information provided to the provider during the initial exit conference has changed.

See timeline example on the following page.

# CHAPTER 20: Complaint Investigations



## Exit Conference Timeline for Complaint Investigations (ALF and ESF Settings)



### Acronyms


- ALF – Assisted Living Facilities
- ESF – Enhanced Services Facilities
- FM – Field Manager
- IDR – Informal Dispute Resolution
- LDDC – Last Date of Data Collection
- SOD – Statement of Deficiency
- POC – Plan of Correction (includes Attestations in this context)
- WD – Working Days



### 7. Exit Conference – Federal Programs only

The exit conference (referred to as the “Oral Summation at Exit” in the EWP) occurs when the CI concludes the investigation. The CI will review issues with the provider, including but not limited to:

- a. Preliminary deficiency findings. Preliminary deficiency findings may be amended if additional information affects the outcome of the investigation.
  - 1) Inform the provider if there is a possible need for further data collection.
  - 2) Inform the provider they will be contacted by telephone or email if any of the information provided during the exit conference changes prior to the issuance of the Statement of Deficiency (SOD).
- b. Ensure that the provider is aware of resident issues in need of immediate attention.
- c. Allow the provider an opportunity to discuss the investigation, ask questions, and present related additional information.
- d. Inform the provider of the SOD process, including:
  - 1) SOD will be sent within 10 working days from the exit conference.
  - 2) Will include a cover letter explaining if an electronic plan of correction (ePOC) is required.
  - 3) Provider requirement to submit the ePOC within 10 calendar days of SOD receipt.
  - 4) Informal Dispute Resolution (IDR) process.
- e. Present the provider with contact information for the FM. Inform the provider that the FM may be a resource for questions regarding the findings.
- f. Thank the provider for their cooperation with the investigation.

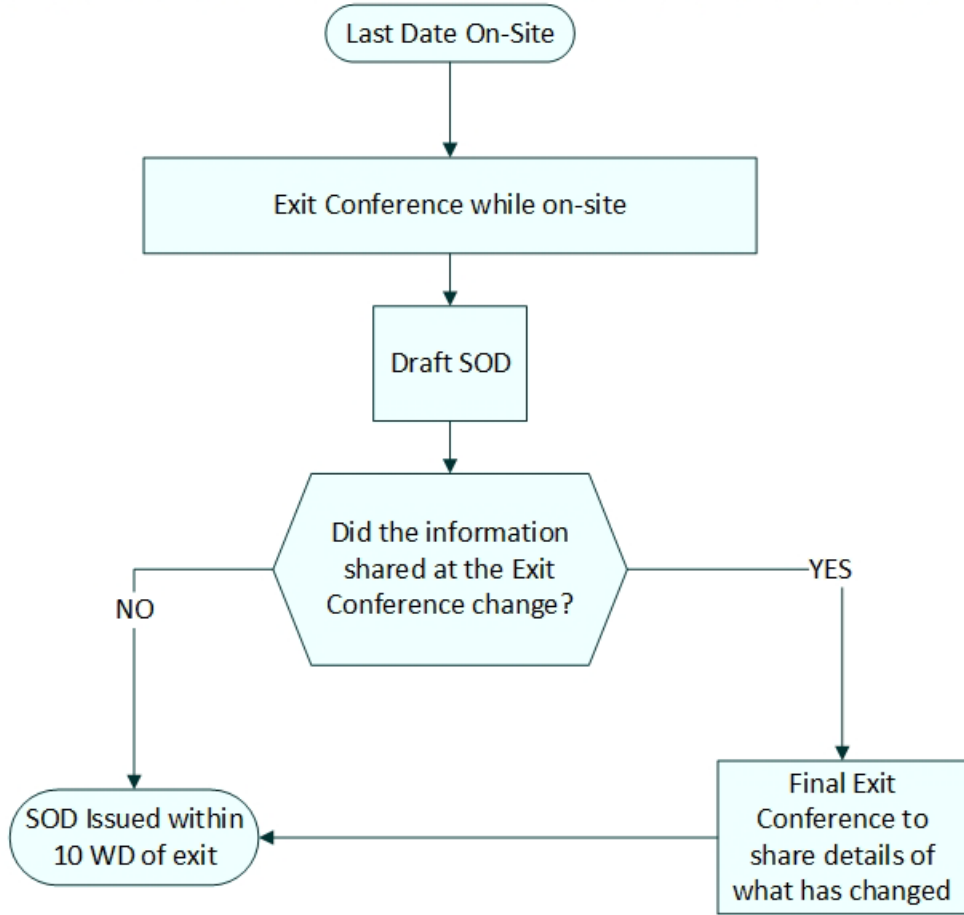
 The CI will document the exit conference, including any plans disclosed by the provider intended to ensure resident safety, in the EWP. Documentation must include at a minimum:

- Date;
- Time;
- Which individual the meeting was with, including their name and title; and
- The outcome relayed to the provider (whether deficient practice was or was not identified).

See timeline example on the following page.



Exit Conference Timeline for Complaint Investigations  
(Federal Settings)



Acronyms

- SOD – Statement of Deficiency
- POC – Plan of Correction (includes ePOC in this context)
- WD – Working Days

# CHAPTER 20: Complaint Investigations



## D. Off-site Activities

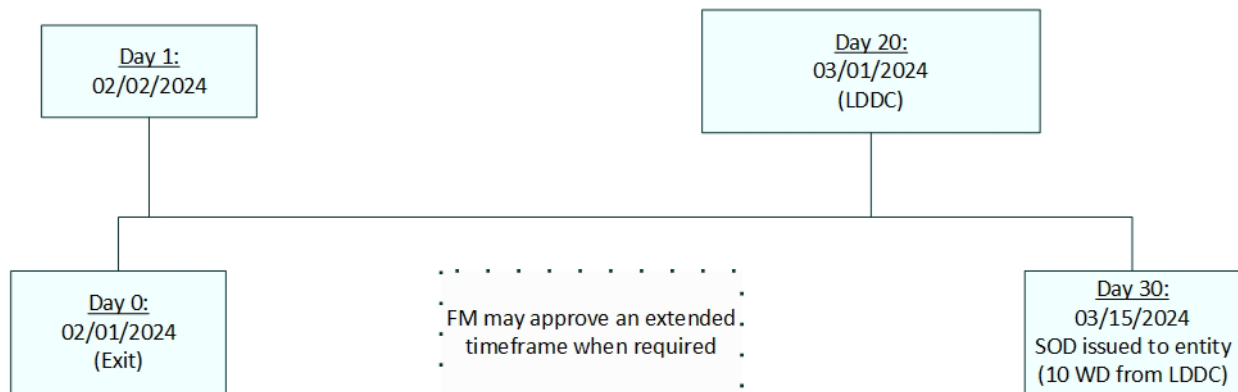
### 1. Final Determination

#### a. AFH and CCRSS only

- 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 20 working days of the [preliminary exit conference](#), unless receiving approval from the FM to extend this time frame (see example below).
- 2) The CI will review and analyze all data pertinent to the complaint and determine if there is deficient practice.
  - a) If deficient practice is identified, the findings will be documented within the Statement of Deficiency (SOD) (see the section labeled [Statement of Deficiencies](#) for more information).
- 3) The CI will coordinate any enforcement recommendations with the FM, if applicable (see SOP [Chapter 7 – Enforcement](#) for more information).

### Example of Timeline for Community Programs

*(timeline is in working days)*



#### Acronyms

- FM – Field Manager
- LDDC – Last Date of Data Collection
- SOD – Statement of Deficiency
- WD – Working days

# CHAPTER 20: Complaint Investigations

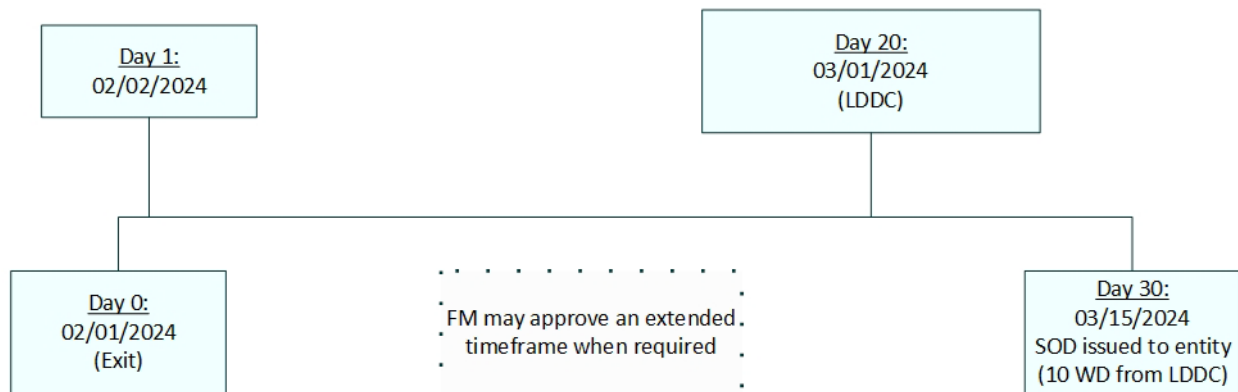


## b. ALF and ESF only

- 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 20 working days of the [initial exit conference](#), unless receiving approval from the FM to extend this time frame (see example below).
- 2) The CI will review and analyze all data pertinent to the complaint and determine if there is deficient practice.
  - a) If deficient practice is identified, the findings will be documented within the Statement of Deficiency (SOD) (see the section labeled [Statement of Deficiencies](#) for more information).
- 3) The CI will coordinate any enforcement recommendations with the FM, if applicable (see SOP [Chapter 7 – Enforcement](#) for more information).

### Example of Timeline for Community Programs

*(timeline is in working days)*



#### Acronyms

- FM – Field Manager
- LDDC – Last Date of Data Collection
- SOD – Statement of Deficiency
- WD – Working days

## CHAPTER 20: Complaint Investigations



### c. Federal Programs only

- 1) The CI will review and analyze all data pertinent to the complaint and determine if there is deficient practice.
  - a) If deficient practice is identified, the findings will be documented within the Statement of Deficiency (SOD) (see the section labeled [Statement of Deficiencies](#) for more information).
- 2) The CI will coordinate any enforcement recommendations with the FM, if applicable (see SOP [Chapter 7 – Enforcement](#) for more information).



### 2. Final Exit Conference – Community Programs

#### a. AFH and CCRSS only

A final exit conference (referred to as “Contact Administrator for Investigation Summary” in the EWP) is only required when:

- 1) Failed practice has been identified; and
- 2) The information given to the provider during the [preliminary exit conference](#) has changed.

The CI will document the following when informing the provider of changes to the information provided during the preliminary exit:

- Date;
- Time;
- Method (i.e., phone call, email, in-person meeting)
- Which individual was informed of the changes and their title; and
- What information changed.

#### b. ALF and ESF only

A final exit conference (referred to as “Contact Administrator for Investigation Summary” in the EWP) is only required when:

- 1) Failed practice has been identified; and
- 2) The information given to the provider during the [initial exit conference](#) has changed.

The CI will document the following when informing the provider of changes to the information provided during the initial exit:

- Date;
- Time;
- Method (i.e., phone call, email, in-person meeting)
- Which individual was informed of the changes and their title; and
- What information changed.

# CHAPTER 20: Complaint Investigations



## 3. Public Complainant (PC) Notification of Investigation Closure

- a. The CI will contact the PC to summarize the investigative findings and inform them an Investigation Summary Report (ISR) will follow (if one was requested). Contact may be made by telephone call or secured email.
  - 1) If during the initial attempt to interview the PC, and the phone number was found to be disconnected, it is not required to attempt to notify the PC of the outcome.
- b. Contact is not required if the PC requested 'no contact' as noted in the intake.

### Example of no contact documentation in STARS

If CRU receives a report from a Public Complainant, and the reporter requests no contact following the report, this may be documented in various ways. Below are two common methods of documenting these requests.

#### 1) In the Incident description:

Incident description

CRU NOTE: THIS REPORTER CHECKED NO CALLBACK

#### 2) In the Follow up information:

Follow up information

7/6/2023 at 913

CRU spoke with

and confirmed her report will be forwarded for investigation.

declined follow up.

Note: the PC must be notified of the complaint closure regardless of whether or not they requested a public outcome letter. This includes hospital staff and first responders. If the CI does not feel a call to the hospital staff or first responder is needed, request supervisor review in the EWP to obtain FM approval to omit this step.

When contacting the PC, document the following in the EWP:

- Date
- Time
- Method of contact
- Summary of information relayed (failed practice was / was not identified).

*\*If the PC is unavailable, it is appropriate to leave a message provided the message does not contain confidential information.*



Refer to the decision tree contained in the section labeled '[Public Complainant \(PC\) Interview](#)' for assistance in determining if contact is required.

# CHAPTER 20: Complaint Investigations



## 4. Statement of Deficiency (if applicable):

a. The CI will:

- 1) Review all pertinent investigative findings and confirm the analysis of deficiency citations.
- 2) Conduct a review with the FM if other questions arise.
- 3) Write the SOD in accordance with the Principles of Documentation found in [SOP Chapter 18 - Across All Settings](#), verifying:
  - a) Findings are supported by at least two sources of evidence.
  - b) The scope and universe of the deficient practice is identified
  - c) Identifying information is not included; and
  - d) Extraneous information irrelevant to the non-compliance is not included.

Note: If Enforcement is recommended, the SOD draft must be provided to the [Enforcement and Compliance Unit](#) for review by the 6<sup>th</sup> working day, prior to being sent to the provider.

b. The FM will:

- 1) Review and approve the SOD, once it has been verified the above criteria were met.
- 2) Issue the SOD to the provider in accordance with [SOP Chapter 18 – Across All Settings](#).
- 3) Coordinate with the CI if enforcement action is recommended and follow [SOP Chapter 7 – Enforcement](#).



## 5. 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 examples 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).

a. The CI will:

1) Complete a separate ISR for each intake, verifying:

a) The allegation description accurately captures the reported concern;

✓ Urinary catheter for identified resident has a strong odor.

or

✓ Quality of care: Urinary catheter for identified resident has a strong odor.

✗ Quality of care

*\*Using only the allegation code does not relay the nature of the reported concern.*

b) If there is more than one allegation, the allegations are sequentially numbered both in the allegation description and in the investigation summary;

c) Each citation (including consultations) is linked to the correct intake number in STARS;

**Note: This is crucial, as it affects whether the system indicates if failed practice was or was not identified in the Conclusion section of the ISR.**

d) When multiple intakes are investigated within the same on-site visit, each ISR only includes information from the referenced intake. It must not reference information or violations from the other intakes investigated within the same on-site visit;

e) All acronyms and abbreviations are explained;

f) All medical jargon is explained;

g) Identifying information is not included; and

h) Summary is brief and clear, without being inflammatory towards any particular person.

Example

✓ "An individual reportedly yells at the named resident."

✗ "The wife yells at the named resident."

## CHAPTER 20: Complaint Investigations



- 2) 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.

- 3) Not mention investigations by any other agencies, such as Adult Protective Services (APS) or Medicaid Fraud Control Division (MFCD).
  - 4) Include only information documented or supported by information found in the EWP.
  - 5) Never include their opinion.
- b. The FM will:
    - 1) Review and approve the ISR, once it has been verified the above criteria were met.
  - c. The Unit AA will:
    - 1) Email or mail the following to the Public Complainant if the “Follow-up requested” box is checked on the intake:
      - a) The Public Outcome Letter generated through STARS; and
      - b) A copy of the ISR.

Note: If the PC requests a copy of the SOD, a public disclosure request must be submitted to [pdd@dshs.wa.gov](mailto:pdd@dshs.wa.gov).

# CHAPTER 20: Complaint Investigations



## E. Follow-up Visits

Follow the procedures contained in the associated document below based on the provider type:

- AFH [SOP Chapter 12 – Adult Family Homes](#)
- ALF [SOP Chapter 13 – Assisted Living Facilities](#)
- CCRSS [SOP Chapter 14 – Certified Community Residential Services and Supports](#)
- ESF [SOP Chapter 15 – Enhanced Services Facilities](#)
- ICF/IID [SOM Appendix J - Intermediate Care Facilities for Individuals with Intellectual Disabilities](#)
- NH [SOM Appendix PP - Interpretive Guidelines for Long-Term Care Facilities](#), following the Critical Element Pathway for the area of concern

Note: If the deficiency was related to background or fingerprint checks, it is appropriate to verify documentation remotely via video call. If the entity provides the documentation via secure email, once the information has been verified, the email may be deleted as a transitory record. Copies of background and/or fingerprint results are not to be maintained in the working papers.



## F. Complaint Closure

A complaint investigation is considered closed when the following have 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 issued.
4. Documentation from the Complaint Investigation is to be archived per the following process:
  - a. Hard copy documents (e.g., signed SODs, certified mail receipts, enforcement actions, etc.) must be sent to Central Files within 10 working days of the complaint investigation closure.
  - b. All the EWPs must be closed and transferred to Perceptive Content within 30 calendar days of complaint closure (see [EWP Quick Start Guide](#) for more information).



Note: If an IDR has been requested, it is helpful for the EWPs to be closed and uploaded prior to the IDR. This supports the IDR team in reviewing all related documentation.



## Part II: Appendices

### A. Unpaid Licensing Fees

#### Purpose

AFHs, ALFs, ESFs, and NHs are required to pay annual licensing fees. The Office of Financial Recovery (OFR) sends an invoice two months before the license fee is due. When the license fee is late due to lack of payment, a Complaint is reported to the Complaint Resolution Unit (CRU) by the Business Operations and Analysis Unit (BOAU). ALFs and ESFs must submit an additional late fee of \$10.00 per day, starting the date following the license expiration and continuing until the fee's mailing date.

Note: CCRSS annual certification fees are managed by Developmental Disabilities Administration.

#### Procedure

1. The BOAU will:
  - a. By the 20<sup>th</sup> of each month, obtain a list of the previous month's overdue accounts for each program, using the [61928 Cleared Renewal Invoice](#) report.
  - b. Compare the list of overdue accounts with the information contained in STARS to determine:
    - 1) If there is a summary suspension or closure; if so, remove that entity from the list.
    - 2) If there has been an increase or decrease to the capacity in the month payment is due. Determine if this resolves the pay discrepancy and, if it does, remove the entity from the list and contact OFR ([ofrpremium@dshs.wa.gov](mailto:ofrpremium@dshs.wa.gov)) to request the amount due be adjusted.
  - c. Forward the final list to the CRU at [dshsaltsa.cru@dshs.wa.gov](mailto:dshsaltsa.cru@dshs.wa.gov).
  - d. Review and monitor the current unpaid licensing fees report monthly. If an entity remains on the report for more than one month, notify the appropriate FM and Compliance Specialist (CS) for further follow up.
2. The CRU will:
  - a. Generate a 20-working day priority complaint intake based on unpaid licensing fees report.
  - b. Follow CRU procedures outlined in [SOP Chapter 4 – Complaint Resolution Unit](#) to assign intakes.
3. The Field Manager (FM) will:
  - a. Assign a complaint investigator (CI) to conduct a complaint investigation, following the procedures outlined in this chapter.
  - b. Inform the investigator if they are notified that the entity has paid their licensing fees in full.
4. The Complaint Investigator (CI) will:
  - a. Review STARS to see if payment has been received.
  - b. If full payment has been received:
    - 1) Complete the required investigation tasks outlined in this chapter.
    - 2) Close the complaint.

## CHAPTER 20: Complaint Investigations



- c. If full payment has not been received:
  - 1) Review compliance with licensing fees for the previous 36 months. If the entity has repeated/recurrent noncompliance, consult with FM.
  - 2) Conduct the complaint investigation, following the procedures outlined in this chapter.
  - 3) Discuss the unpaid licensing fees with the administrator and the expectation that the annual licensing fee is to be paid in full by the due date listed on the invoice.
  - 4) Explain to the provider that RCS is unable to accept partial payments or payment plans.
  - 5) Prepare a Statement of Deficiencies (SOD) if non-payment of the annual licensing fee is verified, following the process outlined in [SOP Chapter 18 – Across All Settings](#), and the Principles of Documentation.
  - 6) Conduct a [follow-up visit](#). If the annual licensing fee has been paid in full and the payment is verified through STARS or any other means, the complaint can be closed.
  - 7) If the full amount of the licensing fees has not been received at the time of the follow-up, refer the facility for enforcement action, following the process outlined below.

### If payment has not been received at time of follow-up

1. The FM will:
  - a. Review the SOD and complete the enforcement referral process in STARS.
  - b. Work with the CI, Compliance Specialist (CS), and BOAU Manager to monitor the facility for payment. Keep complaint open until confirming payment in STARS or with the BOAU Manager.
2. The CS will:
  - a. Review the SOD and enforcement recommendations.
  - b. Facilitate the enforcement process as outlined in [Chapter 7: Enforcement](#) according to the following progression:
    - 1) A condition is imposed stating the home must pay the licensing fees in full within 15 calendar days of the effective date of the condition.
    - 2) If the licensing fees are not paid within 30 days of the effective date of the condition, the home will be issued a stop placement order.
    - 3) If the licensing fees are not paid in full within 30 days of the stop placement order, a civil fine will be imposed.
    - 4) If the licensing fees are still not paid in full after 30 days of the civil fine being imposed, the home may be issued a summary suspension and revocation. See [SOP Chapter 7: Enforcement](#) for information on summary suspension and revocation.

Note: The time between enforcement actions allows time for payments to be processed.

# CHAPTER 20: Complaint Investigations



## B. Fire Safety Code Deficiencies – Community Programs

### Purpose

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

### Procedure

#### SFMO Annual Inspections

The SFMO will:

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

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

The FM will:

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

The Complaint Investigator will:

1. Conduct the investigation based on the information provided by the SFMO.
2. Consult with the SFMO as needed.
3. Draft SOD report including details the SFMO identified as meeting serious fire safety code deficiency(ies) when applicable and any observations validating deficiencies.
4. Consult with FM if additional concerns are identified.

The Compliance Specialist (CS) will:

1. Review the SFMO reports.

## CHAPTER 20: Complaint Investigations



### Serious fire safety code issues

The SFMO is responsible for identifying when concerns meet a serious fire safety code deficiency threshold. Below is the procedure to follow if a potentially serious fire safety code deficiency(ies) is(are) identified during any regulatory visit.

The FM will:

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

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

The CS will:

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

When enforcement remedies will be imposed, the FM will:

1. Provide any enforcement remedy information to the regulator to verbally impose while on-site if RCS staff **are** in the process of completing a regulatory visit at the time.
2. Send a referral to the CRU to generate a 2-Day complaint for RCS investigation if RCS regulators **are not** completing a regulatory visit at the time.
  - a. Assign a CI to go on-site to validate the identified fire safety code deficiency(ies).
  - b. Provide enforcement remedy information to the CI to verbally impose while on-site.
3. Follow STARS enforcement referral process.

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The Compliance AA will:

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

### Facility Compliance

The FM will:

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

The SFMO will:

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

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

The SFMO will:

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

The FM will:

1. Review the SFMO failed re-visit report within 5 working days.
2. Initiate a 10-day intake with CRU unless prioritized differently by the SFMO.
3. Ensure the CI has access to review SFMO reports to establish history of fire safety code deficiency(ies) in preparing for a complaint investigation.
4. Assign a complaint investigator to validate the uncorrected fire safety code deficiency(ies).
5. Provide the draft SOD citing [WAC 388-78A-2040 \(1\)](#) to the CS for review with the SFMO, including correction timelines.

The CS will:

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

### Continued Facility Non-Compliance

The SFMO will:

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

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The FM will:

1. Review the SFMO “NONCOMPLIANCE” report within five working days.
2. Ensure the CI has access to review SFMO reports to establish history of uncorrected fire safety code deficiency(ies) in preparing for a follow-up visit.
3. Assign a CI to complete the follow-up visit to validate the SFMO uncorrected deficiency(ies).
4. Provide the draft SOD to the CS for review with the SFMO, including correction timelines.
5. Follow the STARS enforcement referral process.
6. Coordinate subsequent visits with the SFMO, if necessary.

The CS will:

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

The Compliance unit AA will:

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

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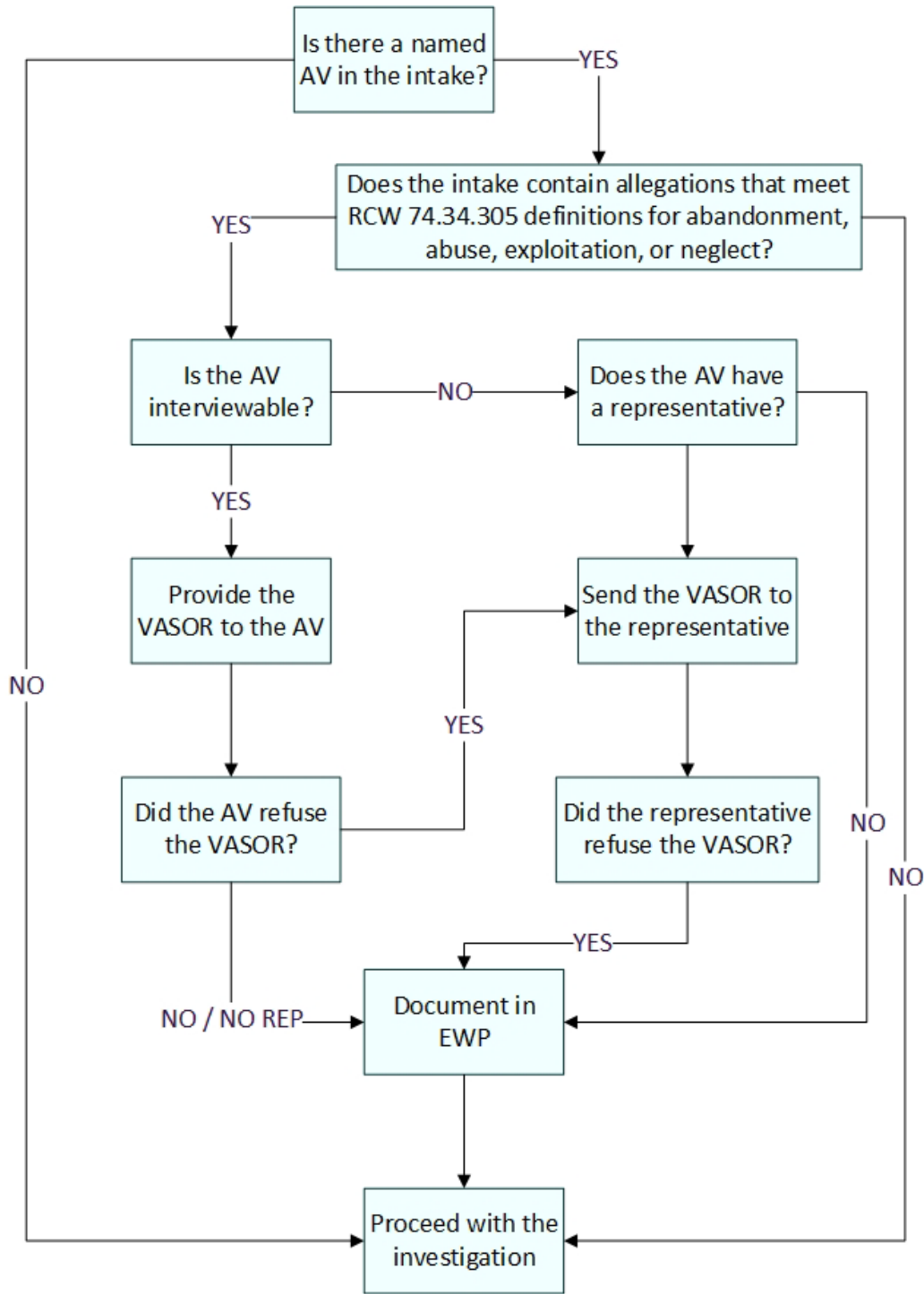


## C. Fire Safety Code Deficiencies – Federal Programs **Under Construction**



## D. Vulnerable Adult Statement of Rights (VASOR)

### 1. VASOR Decision Tree



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## 2. Template Cover Letter



STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
*Home and Community Living Administration*  
*PO Box 45600, Olympia, WA 98504-5600*

Date

Dear Resident Representative,

You are receiving this letter for informational purposes only. The enclosed document details the rights of all residents receiving care and services in long-term care settings. Those rights include the right to be free from abandonment, abuse, financial exploitation, or neglect, as well as the right to report any concerns to the Department of Social and Health Services.

Washington State Law ([RCW 74.34.305](#)) specifies that when the department opens an investigation, the department shall provide a written statement of rights to potentially affected residents or their representative. Provision of this letter should not be taken as notification that abandonment, abuse, financial exploitation, or neglect have occurred. It is for informational purposes only.

This statement is being sent to you as the identified legal representative for Resident Name.

The enclosed document provides you with an explanation of your rights.

If you have any questions, please contact Staff Name, Staff Title, Residential Care Services, at Local Phone Number.

Sincerely,

Field Manager Name, Field Manager  
Residential Care Services



## E. Examples

### 1. 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.

### 2. 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 [Entity]. Is there anything you'd like to share about your experience?



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## 2. Example for All Other Setting Types

  
**Residential Care Services**  
Investigation Summary Report

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<b>Provider/Facility:</b> ABC Provider	<b>Provider Type:</b> Assisted Living Facility
<b>License/Cert.#:</b> 123456	<b>Intake ID:</b> 10001
<b>Compliance Determination #:</b> 120	<b>Region/Unit #:</b> RCS Region 3 / Unit K
<b>Investigator:</b> Jane Doe	
<b>Investigation Date(s):</b> 08/28/2024 through 09/13/2024	
<b>Complainant Contact Date(s):</b> 09/16/2024	

---

**Allegation(s):**

1. Identified resident with injury of unknown origin.
2. Urinary catheter for identified resident has a strong odor.

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**Investigation Methods:**

**Sample:** Total residents: 40  
Resident sample size: 3  
Closed records sample size: 1

**Observations:** Identified resident  
Resident care equipment  
Staff to resident interactions

**Interviews:** Nursing staff  
Direct care staff  
Collateral Contacts

**Record Reviews:** Medical Records  
Fall reports  
Incident investigation

---

**Investigation Summary:**

1. Review of the investigative records showed the facility reported the incident to the department and care plan was updated with preventative measures. Staff interviews and record review showed resident was assessed and medical personnel notified. Collateral contact did not have care concerns related to care. No failed practice identified.
2. Review of medical record showed medical personnel were notified. All physician recommendations and orders were followed. Observations of catheter care followed policies and procedures. No failed practice identified.

---

**Conclusion / Action:**

<input type="checkbox"/>	Failed Provider Practice Identified / Citation(s) Written
<input checked="" type="checkbox"/>	Failed Provider Practice Not Identified / No Citation Written
<input type="checkbox"/>	N/A

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## G. Resources

1. [Electronic Working Papers \(EWP\) How-To Guide](#)
2. [VASOR and Template Letters, including translations](#)
3. Complaint Investigation Request for Documents (Optional use)
  - a. [Adult Family Homes \(AFH\) \(DSHS 17-334\)](#)
  - b. [Assisted Living Facilities \(ALF\) \(DSHS 17-334B\)](#)
  - c. [Certified Community Residential Services and Supports \(CCRSS\) \(DSHS 17-334A\)](#)
  - d. [Enhanced Services Facilities \(ESF\) \(DSHS 17-334C\)](#)
4. [Key Triggers](#)
5. Complaint Investigation Pathways (Federal Programs must refer to [SOM Chapter 5 – Complaint Procedures](#) or the appropriate appendix in the SOM)
  - a. [Adult Family Homes \(AFH\)](#)
  - b. [Assisted Living Facilities \(ALF\)](#)
  - c. Certified Community Residential Services and Supports (CCRSS) – **Under Construction, refer to AFH Pathways for guidance**
  - d. Enhanced Services Facilities (ESF) – **Under Construction, refer to ALF Pathways for guidance**
6. [Filing a Complaint Intake from the Field](#)
7. [Imminent Safety Concerns – Response During Regulatory Visits](#)
8. [Coordination and Communication with Outside Investigative Entities \(including Criminal Mistreatment Indicators\)](#)
9. [Use of Photography](#)



### H. Glossary of Terms

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

**Abbreviated regulatory process** – Gathering of investigative information for a focal issue or issues conducted for complaints, change in ownership, or other indicators of specific concern.

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

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

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

**Agency** – State agency.

**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.

**Alleged perpetrator (AP)** – means the individual(s) perpetrating the alleged abuse, neglect, financial exploitation, or other non-compliance with regulatory requirements.

**Alleged victim (AV)** – means the vulnerable adult(s) identified in the report as allegedly being abused, neglected, financially exploited or the subject of non-compliance with regulatory requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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**Confidential Identifier** – The name, title, or letters/numbers referring to entity staff or those living in the residential setting within a Statement of Deficiency, following guidance contained within [SOP Chapter 18 – Across All Settings, and the Principles of Documentation \(POD\)](#).

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

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

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

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

**Date assigned to field** – is the date the CRU staff ‘linked’ the intake to the appropriate regional office via the administrative assistant, completing CRU’s responsibility for the development of the intake.

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

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

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

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

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

**Duty of care** – This includes:

- 1) A guardian or conservator appointed under [Chapter 11.130 RCW](#);
- 2) An agent granted authority under a power of attorney as described under [Chapter 11.125 RCW](#);  
or
- 3) A person providing the basic necessities of life to a vulnerable adult where:
  - a) The person is employed by or on behalf of the vulnerable adult; or
  - b) The person voluntarily agrees to provide, or has been providing, the basic necessities of life to the vulnerable adult on a continuing basis.

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

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

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

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

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

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citation to be irrefutable.

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

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

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

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

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

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

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**Final Exit Conference [Community Programs]** – means the meeting between the RCS regulator and the Provider, or their designee, to provide the outcome of the survey, evaluation, inspection, or investigation, including any potential identified deficiencies.

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

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

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

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

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

---

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

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

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

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

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

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

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

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**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. Nursing homes must also report vulnerable adult injuries of unknown origin, and any other requirements outlined in [WAC 388-97](#) (Nursing Homes).

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

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**Initial Exit Conference [ALF and ESF]** – means the meeting between the RCS regulator and the Entity to provide the status of the survey, evaluation, inspection, or investigation including any potential identified deficiencies. This meeting occurs on the exit date and is required for all regulatory visits. The provider should be informed of any additional data collection that may be needed and that they will be notified via telephone call or email if the information provided changes.

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**Initiate a response** – are various activities taken by the CRU staff after ‘knowledge’ of a report such as conducting research, calling the reporter, discussing the report with the supervisor, and creating an intake in STARS.

---

**Initiation** – means the first date of the investigation (see definition for Entrance Date).

---

**Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)** – The Social Security Act created this optional Medicaid benefit to fund “institutions” (four or more beds) for individuals with intellectual disabilities. The Secretary defines this as providing “active treatment.”

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**Internet Quality Improvement Evaluation System (IQIES)** – the federal umbrella administrative and computer system that encompasses the MDS and Swing Bed-MDS system, other systems for survey and certification, and home health providers.

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

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

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

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

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

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

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**Long-term care facility** – As defined in [RCW 70.129.010\(3\)](#).

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

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

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**Medicaid Fraud Control Division (MFCD)** – means the statewide division that is responsible for both criminal and civil investigations and prosecution of healthcare provider fraud committed against the State’s Medicaid program. The division also investigates and prosecutes complaints of resident abuse or neglect in healthcare facilities and residential settings.

---

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

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

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

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

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

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

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**Noncompliance [NH]** – means any deficiency that causes a facility not to be in substantial compliance. ([42 § CFR 488.301](#))

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**Nursing facility (NF)** – a nursing home, or any portion of a hospital, veterans' home, or residential habilitation center, that is certified to provide nursing services to Medicaid recipients under [section 1919\(a\) of the federal Social Security Act](#). All beds in a nursing facility are certified to provide

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Medicaid services, even though one or more of the beds are also certified to provide Medicare skilled nursing facility services.

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**Nursing home (NH)** – A term that can include both 24-hour Skilled Nursing Facilities (SNF) and Nursing Facilities (NF). SNFs are those that participate in both Medicare and Medicaid. NFs are those that participate in Medicaid only.

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**Opportunity to correct [NH]** – means the entity is allowed an opportunity to correct identified deficiencies before remedies are imposed.

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

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

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

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

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

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

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**Preliminary Exit Conference [AFH and CCRSS]** – means the meeting between the RCS regulator and the Entity to provide the status of the survey, evaluation, inspection, or investigation including any potential identified deficiencies. This meeting occurs on the exit date or within two working days of the exit date and is required for all regulatory visits. The provider should be informed of any additional data collection that may be needed and that they will be notified via telephone call or email if the information provided changes.

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**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):

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- **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 entity/facility may have investigated the situation and initiated corrective action. Investigation by RCS is required because of the need to determine whether the entity'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.
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- **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 entity appears to have taken appropriate action in response to the situation, and measures have been instituted by the entity 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).

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

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

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

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

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

**Record** – any document or recorded information regardless of physical form or characteristics created, sent, organized, or received by the agency in the course of public business.

**Records retention** – The required minimum amount of time a records series must be retained to meet legal, fiscal, administrative, or historical value as listed on an approved records retention schedule or general records retention schedule.

**Records retention schedule** – a legal document approved by the state or local records committee that specifies minimum retention periods for a records series and gives agencies ongoing disposition authority for the records series after the records' approved retention period has been satisfied.

**Recurring/Repeated** –

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

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

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

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

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

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

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- **Public** – are generally residents or clients, family of residents or clients, Long Term Care Ombudsman staff, facility staff when it is clear they are not making an official facility report or are reporting as whistle blowers, hospital staff, and teachers.
  - **Facility** – are generally facility or agency Administrators or other management staff making a report as the official “facility” or provider report, staff who leave the facility/agency phone number and give permission to call them back, staff who state they reported their call to the hotline to their management.
  - **State Employees** – are generally DSHS staff who are making a report in the natural course of their job duties.
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**Research** – means research conducted in any available database or ancillary program to determine vital information needed in order to determine the appropriate avenue to process report and/or to create an intake in STARS.

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**Resident representative** – means either the resident’s legal representative or the individual filing a complaint involving, or on behalf of, a resident.

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

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

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

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

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

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**Significant change [AFH]** – as defined in [WAC 388-76-1000](#).

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**Significant change [ALF]** – as defined in [WAC 388-78A-2020](#).

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

**Significant change [NH]** – based on MDS/RAI manual.

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

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

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

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

- A substantial impairment of a person's physical condition requiring professional medical treatment.
- Loss of consciousness, concussion, bone fracture, muscle tears, disfiguring lacerations, or wounds requiring multiple sutures.
- Injury requiring corrective or cosmetic surgery.
- Substantial bodily injury involves temporary but substantial disfigurement or loss/impairment of bodily function.
- Injury that creates a substantial risk of death, serious permanent disfigurement, or prolonged loss/impairment of body function.

**Substantial compliance [NH]** – means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements ([42 § CFR 488.301](#))

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

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

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

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

## CHAPTER 20: Complaint Investigations



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**Unsupervised access** – means not in the presence of:

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

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**Volunteer** – an individual who interacts with residents without reimbursement.

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

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**Washington Administrative Code (WAC)** – Regulations of executive branch agencies issued by authority of statutes. Similar to legislation and the Constitution, regulations are a source of primary law in Washington State. The WAC codifies the regulations arranging them by subject or agency.

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

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

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

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# CHAPTER 20: Complaint Investigations



## I. Acronym List

AA	Administrative Assistant
ACO	Aspen Central Office
ACTS	ASPEN Complaints/Incidents Tracking System
AFH	Adult Family Home
ALF	Assisted Living Facility
ALTSA	Aging and Long-Term Support Administration (now HCLA)
AP	Alleged Perpetrator
APS	Adult Protective Services
ASPEN	Automated Survey Processing Environment System
AV	Alleged Victim
BOAU	Business Operations and Analysis Unit
CARE	Comprehensive Assessment and Reporting Evaluation System
CCRSS	Certified Community Residential Services and Supports
CD	Compliance Determination
CDC	Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CHOM	Change in Management
CHOW	Change in Ownership
CI	Complaint Investigator/Investigations
CMS	Centers for Medicare and Medicaid Services
CRU	Complaint Resolution Unit
CS	Compliance Specialist
DCYF	Department of Children, Youth, and Families (formerly Child Protective Services or CPS)
DDA	Developmental Disabilities Administration (now DDCS)
DOH	Department of Health
DOL	Department of Licensing
DPL	Dear Provider Letter
DPS	Deficient Practice Statement
DSHS	Department of Social and Health Services
EARC	Enhanced Adult Residential Care
eCFR	Electronic Code of Federal Regulation
EHR	Electronic Health Record
EMR	Electronic Medical Record
ePOC	Electronic Plan of Correction
ESF	Enhanced Services Facilities
EWP	Electronic Working Papers
FM	Field Manager
FMS	Facility Management System
FRI	Facility Reported Incident
FSA	Field Services Administrator

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GH	Group Home
GTH	Group Training Home
HCA	Health Care Authority
HCBS	Home and Community-Based Services
HCLA	Home and Community Living Administration (formerly ALTSA)
HCS	Home and Community Services
HH	Household Members
HQ	Headquarters
ICF/IID	Intermediate Care Facilities for Individuals with Intellectual Disabilities
ID	Identification
IDR	Informal Dispute Resolution
IFP	Individual Financial Plan
IHP	Individual Habilitation Plan
IISP	Individual Instruction and Support Plan
IJ	Immediate Jeopardy
IPC	Infection Prevention and Control
IPP	Individual Program Plan
iQIES	Internet Quality Improvement Evaluation System
IR	Incident Report
ISP	Individual Support Plan
ISR	Investigation Summary Report
ISS	Instruction and Service Support
L&I	Labor and Industries
LDDC	Last Date of Data Collection
LE	Law Enforcement
LN	Licensed Nurse (includes both RNs and LPNs)
LPN	Licensed Practical Nurse
LSC	Life Safety Code
LTC	Long-Term Care
LTCO	Long-Term Care Ombuds
LTCOP	Long-Term Care Ombuds Program
MAR	Medication Administration Records
MB	Management Bulletin
MFCDD	Medicaid Fraud Control Division
MH	Mental Health
N/A	Not Applicable
NCP	Negotiated Care Plan
NF	Nursing Facility
NH	Nursing Homes
OFR	Office of Financial Recovery
PBSP	Positive Behavior Support Plan
PC	Public Complainant

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PCSP	Person-Centered Service Plan
PDU	Public Disclosure Unit
PHE	Public Health Emergency
POC	Plan of Correction
POD	Principles of Documentation
POL	Public Outcome Letter
PPE	Personal Protective Equipment
QA	Quality Assurance
RA	Regional Administrator
RCS	Residential Care Services
RCW	Revised Code of Washington
RN	Registered Nurse
RO	Regional Office
SA	State Agency
SFM	State Fire Marshal
SFMO	State Fire Marshal's Office
SNF	Skilled Nursing Facility
SOD	Statement of Deficiency
SOM	State Operations Manual
SOP	Standard Operating Procedures
SQC	Substandard Quality of Care
S/S	Scope and Severity
STARS	Secure Tracking and Reporting System
TAR	Treatment Administration Record
TBP	Transmission-Based Precautions
VA	Vulnerable Adult
VASOR	Vulnerable Adult Statement of Rights
WAC	Washington Administrative Code
WD	Working Day

# CHAPTER 20: Complaint Investigations



## J. Change Log

Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
08.01.2025	Entire Chapter	Sunset Review	Updated processes to reflect current systems, provide staff clarity	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part 1.A.1. Assignment and Review of the Intake	Added APS Referral Decision Tree	Provide clarified guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.A.3 Public Complainant (PC) Interview	Added PC Contact Decision Tree	Provide clarified guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.A.4 Contacting the Ombuds – NH Only	Process added	Incorporates MB guidance	MB <a href="#">R25-053</a> Support Call 05.06.2025
08.01.2025	Part I.B. IPC Assessment	Verbiage and Tools updated	Provide current guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.C.3 Sample Selection	Verbiage updated and Decision Tree added	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.C.5 Preliminary Exit Conference	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.C.6 Initial Exit Conference	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.C.7 Exit Conference – Federal Programs Only	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.D.1.a Final Determination – AFH and CCRSS	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.D.1.b	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-R25-080</a> Just in time trainings held on 07/31/2025

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Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
	Final Determination – ALF and ESF			
08.01.2025	Part I.D.1.c Final Determination – Federal Programs	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.D.2.a Final Exit Conference – AFH and CCRSS	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.D.2.b Final Exit Conference – ALF and ESF	Verbiage and requirements updated	Provide clarification and program specific guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.E Follow Up Visits	Section Added	Provide guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.A Unpaid Licensing Fees	Section Added	Provide guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.B Fire Safety Code Deficiencies	Section Added	Provide guidance	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.C.1. VASOR Decision Tree added	Clarified Guidance	Provide clarification	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.C.2. VASOR template letter updated	Updated verbiage	Provide for smoother communication with resident representatives	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part III.E ISR Details	Updated ISR examples to include new AFH format	Provide updated guidance related to current process	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.G Protection of Resident Privacy and Data Security	Information incorporated into general guidelines	Redundant information removed for clarity	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025

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Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
08.01.2025	Part I.D. FM and AA Responsibilities	Information incorporated into Parts I.C.4 & 5	Adjusted for document flow and readability	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.A. Coordination with APS	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part I.D. Referrals	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.C Filing a Complaint Intake from the Field	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.D Use of Photography	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.E Coordination and Communication with APS	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
08.01.2025	Part II.F Reporting Criminal Neglect	Information relocated to Ch. 18 - All Settings	Information extends beyond Complaint Investigations	MB <a href="#">R25-080</a> Just in time trainings held on 07/31/2025
10.03.2023	Part III.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 <a href="#">R23-025</a>
04.07.2023	Glossary	Clarified definitions for reporter and complainant	To provide clarification for field staff	MB issued <a href="#">R22-068</a>
03.20.2023	Complete chapter	Reformatting of entire chapter, with updated guidance to every section to provide clarity	To address persistent confusion	MB <a href="#">R23-025</a> Presentation on All RCS Staff Support Call in February 2023

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Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
9.15.2022 9.29.2022	Complete chapter	<ul style="list-style-type: none"> <li>• Clarification of when and how to distribute VASOR.</li> <li>• 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.</li> <li>• Reorganization and editing.</li> </ul>	<p>To address persistent confusion about distributing the VASOR.</p> <p>To address potential gap in coordination with APS.</p>	<p>Presentation on All RCS Staff Support Call in October 2022</p> <p>MB issued <a href="#">R22-068</a></p> <p>Amended <a href="#">R20-085</a></p>
2.11.2021	<ul style="list-style-type: none"> <li>• 20A Complaint Investigations- All Settings</li> </ul>	<ul style="list-style-type: none"> <li>• IIA- Offsite Preparation, section (1)(b) Attempts to contact the public complainant</li> <li>• IIF- Planning and Investigative Reviews- Reference to state for abuse</li> <li>• IVC- Onsite Activities, section (6) Added corrected</li> </ul>	<p>In relation to a PIP for Nursing Homes and Assisted Living Facilities. Clarification requested.</p>	<p>Posted on document review for 20 days</p> <p>Announced in Community Call February 1<sup>st</sup>, 2021</p> <p>Documented in the 2020 PIP Plan</p> <p>MB issued <a href="#">R21-016</a></p>

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Eff. Date	Chapter/ Section #	Brief Description of Change	Reason for Change	Communication and Training Plan
		references as above; on VASOR matrix 'Time' changed to 'Date' <ul style="list-style-type: none"> <li>• V(B)- Offsite Activities- Documenting the outcome of the exit interview</li> </ul>		
2.11.2020	<ul style="list-style-type: none"> <li>• 20A4 Use of Photography</li> </ul>	Update permissive use of state cell phone	To support cell phone use & the integrity of photo for retention	MB issued <a href="#">R20-011</a> Announced in Newsletter
8.16.2019	<ul style="list-style-type: none"> <li>• 20A Complaint Investigations</li> <li>• 20B Writing ISR</li> </ul>	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: <a href="#">R19-057</a> Announced in RCS newsletter

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