CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT A

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Face Sheet

CCRSS Provider Information		
DOING BUSINESS AS (DBA)	TELEPHONE (WITH AREA CODE)	FAX NUMBER (WITH AREA CODE)
MAILING ADDRESS		EMAIL ADDRESS
PHYSICAL ADDRESS		
ADMINISTRATOR'S NAME	EVALUATION TEAM (INDICATE TEAM LEADER)	
NUMBER OF CLIENTS SERVICE BY PROVIDER	SAMPLED CLIENTS ID NUMBERS	
NUMBER OT TOTAL PERSONNEL EMPLOYED BY PROVIDER	SAMPLED PERSONNEL ID LETTERS	

Enter sample Client ID numbers for the following in the column below	**Enter total number of clients in the column below**
Clients receiving **Group Home Services**:	
Clients receiving **Nurse Delegation**:	
Clients receiving **Community Protection Services**:	
Clients with **Positive Behavior Support Plans**:	
Clients **Prescribed Psychoactive Medications**:	
Clients with **Vocational / Employment Programs**:	
Clients with **Restrictive Procedure***:	
Clients **Performing Work for the Provider Requiring Remuneration**:	
Clients Assessed at **Level 5+**:	
Clients whose **Funds are Managed by Agency**:	
Clients receiving **Crisis Diversion Bed Services****:	
Clients receiving **Crisis Diversion Support Services*****:	

Total number of **Vehicle(s) Operated by Provider**:	Insured? ☐ Yes ☐ No If yes, insurance company name (notify FM if no insurance):
Other information gathered:	
Alternate office sites:	

* **Restrictive procedure**: Any procedure that restricts a client's freedom of movement, access to client property, requires a client to do something, which s/he does not want to do, or removes something the client owns or has earned. Examples: locked sharps, window / door alarms, locked food, etc.

** **Crisis diversion bed services:** Crisis diversion that is provided in a residence maintained by the service provider.

*** **Crisis diversion support services:** Crisis diversion that is provided in the client's own home.

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT B

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Supports Observation

CLIENT NAME	CLIENT SAMPLE ID NUMBER
DATE OF CLIENT OBSERVATIONS (OBSERVATIONS IN CLIENT HOME UNLESS OTHERWISE NOTED)	

The information listed in the left box of each category is a guideline, document observations in the right box.
If no observation occurred, mark the "Not Observed" box for that section.

A. Staff / Client Interactions **Time of Observation:** ☐ **Not Observed**

What staff instruction and supports were observed?

Staff name:

YES	NO	N/A		YES	NO	N/A	
☐	☐	☐	Were staff to client interaction(s) responsive and meeting client needs?	☐	☐	☐	Was staff / client communication appropriate?
☐	☐	☐	Did staff refrain from speaking over clients or in another language?	☐	☐	☐	Was there recognition of the client's cultural diversity and preferences?
☐	☐	☐	Did staff respect the client's dignity, privacy, and rights?				

B. Meals **Time of Observation:** ☐ **Not Observed**

What meal(s) were observed?

Any dietary restrictions?

Did the meal appear balanced and nutritious?

Were the restrictions accommodated?

☐ Yes ☐ No

C. Medication Assistance **Time of Observation:** ☐ **Not Observed**

What kind of assistance did the client require for medications?

Who prepared the medications? Preparation includes removing the pills from the bottle / blister pack or bubble.

☐ Staff ☐ Client

How did the client take their pills?

Was the medication mixed in food? (388-101D-0310)

☐ Yes ☐ No

Was the medication crushed?

☐ Yes ☐ No

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT C

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Interview

CLIENT NAME	CLIENT SAMPLE ID NUMBER
DATE OF CLIENT INTERVIEW	TIME OF CLIENT INTERVIEW

Document client answers to the questions or declination to answer the questions on the right side of the box. Ask at least one question or a related question for Section B - K.

☐ **Check here if the client is not capable of being interviewed.** ☐ **Check here if the client declined the entire interview.**

If a box above is checked, skip rest of form, and move to next form.

The following are REQUIRED questions and MUST be asked during the interview. Check "Y," if the answer is yes; check "N," if answer is no and document the interviewee's response; or check "D," if the interviewee declined to answer the question; or check "N/A" if the question was not asked because it does not apply to that client (i.e., client does not have a roommate). The questions in this section were developed with CMS as part of a waiver and CANNOT be modified.

Y	N	D	N/A	Question
☐	☐	☐	☐	Can you make choices about the care and services you receive here at the home?
☐	☐	☐	☐	If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to?
☐	☐	☐	☐	Do you have an opportunity to participate in community activities?
☐	☐	☐	☐	Can you choose who visits you and when?
☐	☐	☐	☐	Do they pay attention to what you have to say?
☐	☐	☐	☐	Can you choose to lock your door?
☐	☐	☐	☐	Do you have access to food anytime?
☐	☐	☐	☐	Do you receive services in the community?

A. Overall Satisfaction and Responses to Concerns	☐ **Declined to Answer**
What do you like about living here?	
B. Care and Service Needs	☐ **Declined to Answer**
Do you get the help that you need?	
C. Support of Personal Relationships	☐ **Declined to Answer**
Do you have friends or relatives in the community that you visit with?	
D. Restrictions	☐ **Declined to Answer**
Does anyone tell you that you can't do things you want to do?	
E. Respect of Individuality, Independence, Personal Choice, Dignity (meals, activities, money)	☐ **Declined to Answer**
Can you make your own choices?	
F. Environment	☐ **Declined to Answer**
Tell me about your room is decorated and did you help?	
G. Health and Safety	☐ **Declined to Answer**
Do you feel safe here?	
H. Food / Shopping / Preferences	☐ **Declined to Answer**
Does anyone share your food?	
I. Social Activities / Work	☐ **Declined to Answer**
What kinds of things did you do for fun?	
J. Finances	☐ **Declined to Answer**
Does anyone tell you how you can spend your money?	

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Finances Record Review

CLIENT NAME	CLIENT SAMPLE ID NUMBER	DATE OF RECORDS REVIEW

Finances

Does the provider manage client funds?	☐ Yes	☐ No
Signed IFP?	☐ Yes	☐ No
Guardian / Client approved?	☐ Yes	☐ No
Client finances contact / title:		
Are there staff that may assist?	☐ Yes	☐ No
Are there shared expenses?	☐ Yes	☐ No
Any fees or late charges?	☐ Yes	☐ No
Any provider loans?	☐ Yes	☐ No
Mismanaged / lost / stolen funds?	☐ Yes	☐ No
Property record?	☐ Yes	☐ No

	Checking			**Cash / Gift Cards**			**EBT**			**Other**
	Yes	No	N/A	Yes	No	N/A	Yes	No	N/A	
Ledger	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Reconciled / verified	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Receipts over $25	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Running balance	☐	☐	☐	☐	☐	☐	☐	☐	☐	

WACs: 388-101-3020 (Compliance)
388-101D-0235 (Shared expenses and client related funds)
388-101D-0240(1,6,9) (Individual financial plan)
388-101D-0245(8) (Managing client funds)
388-101D-0255 (Reconciling and verifying client accounts)
388-101D-0270 (Client financial records)
388-101D-0285 (Client reimbursement)
388-101D-0390 (Client's property record)

Notes

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Client Record Review

CLIENT NAME	CLIENT SAMPLE ID NUMBER	DATE OF RECORDS REVIEW

Client Characteristics

Level 5+	G	GP	AE	NEW	ND	NV	MED	PBS	RES	CP	ALARMS	IFP	GH

Diagnosis:

PCSP

Assistance Levels:	F	P	V	M	N
Taking medications	☐	☐	☐	☐	☐
Avoiding health and safety hazards	☐	☐	☐	☐	☐
Obtaining medical services	☐	☐	☐	☐	☐
Managing money	☐	☐	☐	☐	☐
Protecting self from exploitation	☐	☐	☐	☐	☐

PCSP effective date:

PCSP signed by:

Extensive medical concerns:

Extensive behavioral concerns:

IISP

IISP; date:

Functional Assessment; date:

Yes	No	
☐	☐	6-month review
☐	☐	Goals defined
☐	☐	IISP with methods
☐	☐	IISP approval

Yes	No	
☐	☐	Implementation of goals
☐	☐	Risks and interventions identified
☐	☐	PCSP based instructions and support

Yes	No	
☐	☐	Target behavior
☐	☐	Behavior function
☐	☐	Finalized within 45 days

Medical Information

Physical date:

Dental date:

FOLLOW-UP ON MEDICAL

OTHER MEDICAL (PODIATRY / EYE / ETC.)

PROTOCOLS

Medical Devices

	Yes	No	N/A
Current doctors' orders?	☐	☐	☐
Consent?	☐	☐	☐
Instructions / plan?	☐	☐	☐

Nurse Delegation: ☐ Yes ☐ No; if yes, complete below:

Yes	No	
☐	☐	Consent (date:)
☐	☐	Instructions available to staff
☐	☐	90 Day Review

☐ Oral ☐ Topical ☐ Drops: eye / ear

☐ Tube feedings ☐ Insulin

☐ Other:

Observations / interviews:

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)
CLIENT NAME	CLIENT SAMPLE ID NUMBER

PBSP

Date:

Restrictive procedures: ☐ Yes ☐ No

If yes, complete below:

Date:

	Yes	No	N/A
Client / guardian consent	☐	☐	☐
Housemate consent	☐	☐	☐

Community Protection (CP): ☐ Yes ☐ No

If yes, complete below:

Date:

	Yes	No	N/A
Treatment plan	☐	☐	☐
CP chaperone agreement	☐	☐	☐
CP Residential housing	☐	☐	☐
Mixed CP housing	☐	☐	☐
Psychosexual / CP risk assessment	☐	☐	☐

REASON FOR FUNCTIONAL ASSESSMENT (CHECK ALL THAT APPLY) ☐ N/A

☐ Self-injury ☐ Psych meds – PRN ☐ Suicide attempt ☐ Assault or injury to others ☐ Physical restraints

☐ Sexual aggression ☐ Emotional outburst ☐ Property destruction ☐ Restrictive procedures

☐ Other:

Medications

MAR Review	Yes	No	N/A
Medications noted on MAR were available in the medication supply	☐	☐	☐
Staff initials on MAR indicate medications given as prescribed for the month	☐	☐	☐
Medication list and purpose	☐	☐	☐

Psych Meds: ☐ Yes ☐ No; if yes, complete below:

	Yes	No
Instructions available to staff?	☐	☐
Monitoring side effects?	☐	☐
Psych med list and purpose	☐	☐

Date met with prescriber:

Provider present? ☐ Yes ☐ No

If no, who accompanied client?

Incident Reports

Notes:

RELEASE OF INFORMATION (ROI):

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

CLIENT NAME	CLIENT SAMPLE ID NUMBER

Related WACs	
388-101D-0025 Service provider responsibilities **388-101D-0060** Policies and procedures **388-101D-0130** Treatment of clients **388-101D-0150** Client health services support **388-101D-0150 (5)** Health services monitoring **388-101D-0150(7)** Annual physical / dental **388-101D-0155** Medical devices **388-101D-0180** CP and other clients **388-101D-0205** IISP **388-101D-0210 (2)(b)** IISP Development - instruction and support **388-101D-0215** IISP Documentation **388-101D-0215(5)** IISP Documentation (agreement) **388-101D-0230** Ongoing IISP updates **388-101D-0355** Psychotropic Medications	**388-101D-0370** Confidentiality of client records **388-101D-0385** Contents of client records **388-101D-0385(2)(d)** Health provider contact information **388-101D-0405** When is F.A. required? **388-101D-0410** When is PBSP required? **388-101D-0425(2)(c)** Restrictive procedures-PBSP strategies **388-101D-0425(3)** Restrictive procedures - termination of **388-101D-0470(2)** CP policies and procedures - chaperone **388-101D-0470(3)** CP policies and procedures - compliance with laws **388-101D-0485** CP treatment plan **388-101D-0490(1)** CP client records – psychosexual / risk assessments **388-101D-0500** CP client home location **388-101-4150** Mandatory Reporting-CRU **388-101-4160** Mandatory Reporting-Law Enforcement

Notes:

CCRSS PROVIDER NAME		CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)	

ATTACHMENT F

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Family / Representative / Collateral Contact Interview

CLIENT NAME		CLIENT SAMPLE ID NUMBER
DATE OF INTERVIEW	TIME OF INTERVIEW	
☐ If interview is not with a court-appointed guardian, check here if the client did not give permission for a collateral interview. If the box is checked, skip rest of form, and move on.		
CONTACT NAME AND NUMBER		RELATIONSHIP TO CLIENT
CONTACT ATTEMPTS		
What do you like about the services the provider provides to the client?		
Does the provider and staff provide the support to the client in a manner that encourages the client to do things for themselves to learn and grow? Please describe.		
Are there any areas the provider and their staff could improve upon?		
Do you have any concerns about the care the client receives?		
Are there any services or assistance that you would like to see that is not currently offered?		

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT G

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Staff Interview

CLIENT NAME	CLIENT SAMPLE ID NUMBER	DATE OF INTERVIEW
STAFF NAME	STAFF SAMPLE ID NUMBER	TIME OF INTERVIEW

A. Client Needs	
Tell me about the instruction and supports that you provide to client.	
How did you learn about client's needs and how to provide instruction and supports to her/him?	
B. Client Health Care and Medication	**WAC 388-101D-0185 (services), WAC 388-101D-0325 (medications)**
Tell me about client health care needs.	
What kind of medication assistance does client need?	
Are there nurse delegations for any task?	
What medical concerns are you following?	
What kinds of medications does client take?	
Where can you find information on the side effects?	
What is the process if a client refuses to take their medication?	
C. Finance / Food / Meals	**WAC 388-101D-0235**
What assistance does the client need to pay bills and buy food?	
Where is the EBT card kept?	
Who can use it?	
Who does the food shopping and how often?	
How is the food purchased, stored, and prepared?	
Do the client's share food or eat meals family style?	
Who does the cooking?	
Do you know what a healthy diet is? How do you assist the client with a healthy diet?	
D. Mandatory Reporting	**WAC 388-101-4150, WAC 388-101-4160**
What is Mandatory Reporting?	
How would you know if a client was being abused, neglected, or financially exploited?	
E. Positive Behavior Support Plan	**WAC 388-101D-0400, WAC 388-101D-0405, WAC 388-101D-0410**
If the client has a Positive Behavior Support Plan, how do you access it?	
What behaviors are note?	

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT H

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Group Training Home (GTH)
Home Environment and Safety Worksheet

Observations of the environment occur throughout the certification evaluation process.

CLIENT NAME	CLIENT SAMPLE ID NUMBER
DATE OF OBSERVATIONS	TIME OF OBSERVATIONS

Quality of Life / Client Rights			
Yes	No	N/A	
☐	☐	☐	Did the client have a shared bedroom (only if they consent)?
☐	☐	☐	Was the client’s bedroom furnished and decorated within the term of their written agreement with the GTH?
☐	☐	☐	Can client retain and use personal possessions, including furniture and clothing, as space permits?
☐	☐	☐	Does the client have control of their own schedule as indicated in their PCSP?
☐	☐	☐	Is the client able to meet privately at any time with visitors of their choosing?
☐	☐	☐	Can the client access and review the GTH’s certification results and correction action plans?
☐	☐	☐	Can the client access and review the GTH’s policies and procedures?
☐	☐	☐	Can the client view written notice from GTH of enforcement actions that places a hold on referrals for new clients?
☐	☐	☐	Does the client have a written agreement with the GTH regarding client’s notice of rights for termination?
Physical Environment and Outdoors			
Yes	No	N/A	**Bedroom:**
☐	☐	☐	Does the bedroom have adequate square footage (80 sq. ft. single, 140 sq. ft. double, 120 sq. ft. double if licensed before 01/01/2019)?
☐	☐	☐	Is the bedroom private unless client requests to share?
☐	☐	☐	Window / door provides natural light. Covered with a screen, and allows for emergency exit?
☐	☐	☐	Does the room have a closet or wardrobe (not included in usable square footage)?
☐	☐	☐	Does the room have a locking bedroom door (unless unsafe for client per PCSP)?
☐	☐	☐	Clean, comfortable bed with waterproof mattress if needed or requested by client?
☐	☐	☐	Adequate space for mobility aids (i.e., wheelchair, walker, lifting devices)?
☐	☐	☐	Direct, unrestricted access to common areas?
☐	☐	☐	Construction changes or significant structural change to the home?
☐	☐	☐	Home has been adapted to meet the client’s needs?
☐	☐	☐	Fixtures, furnishings, and exterior are safe, sanitary, and well-maintained?
☐	☐	☐	Hot surfaces, such as fireplace, wood-burning or pellet stove have a stable barrier?
☐	☐	☐	Pets: proof of current vaccinations?
Bathrooms			
Yes	No	N/A	
☐	☐	☐	Handwashing sinks with hot and cold running water?
☐	☐	☐	Direct access to toilet and shower?
☐	☐	☐	Toilets (1:5 ratio)?
☐	☐	☐	

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

Safety

Yes	No	N/A	
☐	☐	☐	Smoke detectors in every client's bedroom; on every floor of home, and interconnects so when one alarm is triggered, the whole system reacts?
☐	☐	☐	Smoke detectors in working condition and meets the needs of the specific clients?
☐	☐	☐	Fire extinguishers (5 lb. 2A; 10B-C) on each floor of the home?
☐	☐	☐	Fire extinguishers installed to manufacturer's recommendations, annually replaced / inspected or serviced and in working order?
☐	☐	☐	Facility located in are with public fire protection?
☐	☐	☐	Annual inspection by the state fire marshal?
☐	☐	☐	Emergency evacuation plan posted in a common area on every floor that displays clearly marked exits, evacuation routes and location for clients to meet outside the home?
☐	☐	☐	Emergency food and drinking water supply to meet needs of clients and staff for 72 hours and meets the dietary needs of each client?
☐	☐	☐	Does a fence at least 48 inches high enclose bodies of water over 24 inches deep? Is there a door or gate that leads to the bodies of water with an audible alarm?
☐	☐	☐	Infection control practices followed?

Safety

Temperature:	ºF	Date / time:	☐ A.M.	☐ P.M.	☐ Kitchen	☐ Other:
Temperature:	ºF	Date / time:	☐ A.M.	☐ P.M.	☐ Bathroom	☐ Other:
Temperature:	ºF	Date / time:	☐ A.M.	☐ P.M.	☐ Kitchen	☐ Other:
Temperature:	ºF	Date / time:	☐ A.M.	☐ P.M.	☐ Bathroom	☐ Other:

NOTES

CCRSS PROVIDER NAME	CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Residential Cost Report – ISS Hours Review / Questionnaire

The ISS Hours Review / Questionnaire documents a sample of the providers ISS process to determine if there are anomalies requiring more detailed review by the Developmental Disabilities Administration (DDA) and/or the Office of Rates Management.

ISS Verification
Obtain the most recent cost report Schedule B submitted by the provider from the RCS Field Manager (or designee). Ask the provider to reconcile the gross payroll reported on Schedule B, cell N65 with the provider's internal source payroll summary records. If the gross payroll on Schedule B matches the provider's payroll record(s) supplied (or the variance is less than 2%), complete the heading on the ISS Review / Questionnaire form and write "Gross payroll amounts match within the guidelines" in the comment section of the form. If the Schedule B reported amount does not match the provider's payroll summary, forward the information to the RCS Field Manager (or designee), so it can be sent with copies of the working papers to the Office of Rates Management for a further ISS review. Evaluator will submit findings to the RCS Field Manager. The RCS Field Manager will report any material discrepancies found to Office of Rates Management, Management Services Division, and the Developmental Disabilities Administration.

Comments
Schedule B reviewed per new process effective April 2021. Gross payroll amounts match within guidelines.

FIELD MANAGER	DATE REVIEWED

Note: Schedule B will be provided by Office of Rates Management to the RCS Field Manager prior to certification evaluations.

CCRSS PROVIDER NAME	CERTIFICATION NUMBER	RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATES

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Certification Evaluation Staff Sample / Record Review

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D							
Hire Date								
Training before working alone (IISP, emergency procedures, reporting requirements, client confidentiality)	0095							
Staff Training within four weeks (mission statement, policies, and procedures, on the job training)	0055 0100							
75 hours of basic training within 120 days - indirect supervision required until then or Exemption Letter	0087	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER	☐ EXEMPTION LETTER
Staff Training within six months (client services, residential guidelines, positive behavior support), Bloodborne Pathogens with HIV/AIDS)	0105							
First Aid and CPR (within the first 6 month of hire and current)	0105 0110							
Nurse Delegation Training	0160							
NAR/NAC Training	0160 0315							
CP Training	0480							
Continuing Education (12 hours per calendar year)	0100							
Annual review of DSHS 10-403 (Abuse / Neglect)	0500							
THE FOLLOWING TWO QUESTIONS ARE SETTING SPECIFIC, IF N/A IS MARKED, THE ENTIRE ROW WILL BE CONSIDERED N/A, AS THIS INDICATES IT DOES NOT APPLY TO SETTING BEING REVIEWED.								
COVID (vaccine or exemption) (SOLA only) ☐ N/A								
TB Test (GTH only) ☐ N/A	0655							

CCRSS PROVIDER NAME	CERTIFICATION NUMBER	RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATES

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Background Record Review

Instructions: Sample should include staff who have been hired since last certification.

Result Type Meanings: NR – No Record; RR – Review Required; D – Disqualify; A – Additional Information needed.

Staff Identifier	WACs	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF	STAFF
Name	388-101D								
Hire Date									
Date WA State Name and Date of Birth (WNDOB) background check completed	0075								
WNDOB Result Type		☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A	☐ NR ☐ RR ☐ D ☐ A
Date of Character, Competence and Suitability Review (CCSR) following WNDOB. N/A if no record		☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
Date Final Fingerprint Check completed	0070								
Fingerprint Result Type	0070	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A	☐ NR ☐ RR ☐ D ☐ A ☐ N/A
FBI Record of Arrests and Prosecutions (RAP), in employee file?		☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A	☐ Yes ☐ NO ☐ N/A
Date of CCSR following fingerprint check. N/A if no record		☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A

CCRSS PROVIDER NAME	CERTIFICATION NUMBER

RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)

ATTACHMENT M

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Group Training Home Food Service Observations and Interviews

Food Service must meet the requirements of WAC Food Code Chapter 246-215 and WAC 388-101D-0575.

Certification Type: ☐ Initial ☐ Annual ☐ Follow up ☐ Complaint: Number ________________________

Food Services: General observation of kitchen and staff (wear a hair restraint per regulation and facility policy).

- ☐ Overall cleanliness of kitchen area (6505)
- ☐ Proper hand hygiene and glove use (02305 and 02310) during food preparation and service
- ☐ Staff cleanliness, use of hair restraints and hygienic practices (02325, 02335, 02410)
- ☐ Food stored with proper temperature controls (for example, no potentially hazardous foods, such as beef, chicken, pork thawing at room temperature) (03510)
- ☐ Food from approved sources (03200) (for example food from known providers, no home prepared items)
- ☐ No ill food workers present (02220)
- ☐ Chemicals labeled and properly stored (07200)
- ☐ Person in charge to provide a copy of the food handlers' cards for meal preparation staff observed during the meal observed in this inspection. (02120)
- ☐ Person in Charge describes process for staff to report illnesses and procedures used when an ill food worker reports an illness (02205, 02220, 02225)
- ☐ Person in Charge or designee describes proper dishwashing procedure that follow manufacture guidelines for temperature or chemical controls (04555, 04560)
- ☐ Person in Charge or designee describes steps taken to prevent cross-contamination of food items (03306)

Notes:

Food Preparation and Service: Observe for proper food preparation, thawing of frozen items, areas used for food preparation, and proper temperature controls, for example.

- ☐ Person in Charge or designee describes how food contact surfaces are thoroughly cleaned/rinsed/sanitized (4640 washing, 04645 rinsing, 04700 sanitization)
- ☐ Person in Charge describes process to check food temperatures
- ☐ Person in Charge or designee identifies proper cooking time and temperatures for potentially hazardous foods (for example, poultry 165°F, ground meat at least 155°F, fish, and other meats 145°F)
- ☐ Person in Charge or designee describes how food items are properly reheated (03400)
- ☐ No bare hand contact with ready to eat foods, except during the washing of fruits and vegetables (03300)
- ☐ Proper hand hygiene and glove use (see above)
- ☐ Fruits and vegetables are thoroughly rinsed (washed) (03318)
- ☐ Hot foods held at ≥135°F prior to serving (03525) **(facility can check food temperature in your presence or you can check temperature of food with your sanitized thermometer)**
- ☐ Cold foods held at ≤41°F prior to serving (03525) **(facility can check food temperature in your presence or you can check temperature of food with your sanitized thermometer)**

Notes:

CCRSS PROVIDER NAME		CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)	

Food Storage: Observe for food storage to prevent contamination and to promote proper temperature controls.

- ☐ Store rooms free from rodents and pests (06550)
- ☐ Refrigerator temperature is maintained at ≤41°F (internal temperature of potentially hazardous food must be at ≤41°F) (03525)
- ☐ Foods are frozen in freezer (no specific temperature requirement) (03500)
- ☐ Raw meats stored below or away from ready to eat food (03306)
- ☐ Potentially hazardous foods are properly cooled (within two hours going from 135°F to 70°F and then to ≤41°F within a total of six hours **or** following the rapid cooling procedure of continuous cooling in a shallow layer of 2 inches or less, uncovered, protected from cross contamination, in cooling equipment maintaining an ambient air temperature of ≤41°F or other methods as described in regulation) (03515)

Notes:

Food Storage: Observe for food storage to prevent contamination and to promote proper temperature controls.

- Menus:
  - ☐ Provide Variety
  - ☐ Are nutritious, meets the clients' dietary needs
  - ☐ Are palatable and served at proper temperature (if issues with food palatability temperature and/or palatability, consider obtaining a meal sample)
  - ☐ Are attractively served
  - ☐ Alternate choices for entrees are available
  - ☐ Prescribed diets available per diet manual
  - ☐ Menus are posted
- Dining Observation:
  - ☐ Clients who need assistance for eating or swallowing concerns receive it timely, appropriately and in a dignified manner
  - ☐ Meals are distributed in a timely manner
  - ☐ For each sampled client being observed, identify any special needs and interventions planned to meet their needs
  - ☐ Tables adjusted to accommodate wheelchairs
  - ☐ Clients prepared for meals, dentures, glasses and/or hearing aides are in place
  - ☐ Adaptive equipment is available per need
  - ☐ Clients at the same table are served and assisted concurrently
  - ☐ Sufficient staff are available for the distribution of meals and assistance
  - ☐ Sufficient time is allowed for clients to eat
  - ☐ Sufficient dining space available in all dining areas
  - ☐ Dining atmosphere is pleasant
  - ☐ Family members are accommodated for dining with their client
  - ☐ Meals are provided as written on posted menu
  - ☐ Meals provided in client rooms are served promptly to ensure proper

Notes:

CCRSS PROVIDER NAME		CERTIFICATION NUMBER
RCS CONTRACTED EVALUATOR / STAFF NAME	CERTIFICATION EVALUATION DATE(S)	

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)

CCRSS Notes

CLIENT(S)	STAFF