

ADULT FAMILY HOME SPECIALTY TRAINING

WASHINGTON STATE LONG-TERM CARE OMBUDSMAN PROGRAM

AGENDA

MODULE I: ADULT FAMILY HOME STANDARDS

1. What are Adult Family homes and why are they different?
2. Value of the ombudsman visits
3. Joint efforts to raise standards
4. Standards used in AFHs
 - Learning Activity: How to Use Regulations
5. Regulatory activities
6. Understanding Citations
 - Learning Activity: Reading Citations

MODULE II: ADULT FAMILY HOME VISITS

1. Motivating the provider
2. Visits
 - Learning Activity: Interactions with Providers
 - Learning activity interviewing residents
2. Documentation of problems for referral
 - Learning Activity: Review of attachments
3. Review of attachments
4. Additional questions
5. Summarize the days learning

ADULT FAMILY HOME SPECIALTY TRAINING

LONG-TERM CARE OMBUDSMAN PROGRAM

LEARNING OBJECTIVES:

Participants will:

- Understand the unique differences in adult family homes as compared to other licensed care settings.
- Build on knowledge of ombudsman role to develop skills in advocating for resident choice.
- Increase skills in problem-solving when visiting adult family homes.
- Enhance observation skills and identify potential indicators of abuse and neglect.
- Understand how to access the standards of care expected in adult family homes.

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MODULE I

ADULT FAMILY HOME STANDARDS

INTRODUCTION

Review of the ombudsman role (by regional ombudsman):

"First a new ombudsman needs to be trained to be an effective ombudsman, and then they can learn about AFHs."

Karen Hausrath – Regional Ombudsman Pierce County

Focus on:

- How the volunteers can make a difference in this unique setting.
- Review how this is different from a regulatory role.
- What the level of supervision will be and expectations on when and how volunteers will contact the Regional ombudsman.

WHAT ARE ADULT FAMILY HOMES (AFH) AND WHY ARE THEY DIFFERENT?

The following legal definition is found in *RCW 70.128.010*

"Adult family home" means a residential home in which a person or persons provide personal care, special care, room, and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services.

- The first homes were established for persons who were developmentally disabled and were patterned after existing foster home programs for children.
- They provide necessary supervision, assistance with activities of daily living, and social services. Some provide nursing care or may specialize in serving persons with mental health problems, developmental disabilities, or dementia.
- Federal requirements generally do not apply only state laws and regulations.
- To start the process to be licensed, the applicant need only be twenty one years of age, have a GED or equivalent, be free from a disqualifying crime or finding, have 320 hours of successful care giving experience, be literate in the English language or meet alternative language requirements and have the mental, emotional, and physical ability to care for others.
- There are no requirements for professionally licensed nurses to staff the basic licensed home. If an AFH admits residents who have nursing needs, the

owner/manager must coordinate and assure that the nursing services are provided.

- Therefore, there are few limitations on what kind of residents can be cared for in an AFH as long as their needs are met, which can result in residents with very heavy care needs, with caregivers with minimal education or training. Often English is a second language.
- The size and nature of adult family homes is both a weakness and strength.
 - A small quiet homelike setting where really close relationships develop benefits many residents.
 - At minimum the staffing ratio is six residents to one staff person, which can be a much better staffing ratio than what is found in nursing homes or assisted living.
 - Residents are limited in their choice of caregivers in a small setting.
 - AFHs can be an isolated setting where things can get very bad very fast and not be noticed.

RESIDENTS IN AFHs ARE MORE VULNERABLE:

- This is a care-giving setting that may involve only a provider and very physically and mentally dependent residents. Residents may be unable to ask for help if abused or neglected or may fear retaliation if they are unable to speak up with concerns.
- There may be very few visitors or professionals in the home over long periods of time, thus there may be no one to advocate for residents or call in complaints for investigation.
- Family and friends who visit residents may not readily identify care problems such as skin ulcers or medication errors.
- Activities may be minimal. Residents may be found sitting in front of the television watching a program that is not of interest. Outside activities may be limited; group activities may not occur.
- The provider may not have the skill to recognize conditions that need nursing or medical attention until the problem has progressed to a serious status.
- There are limited requirements for rehabilitation of residents.
- The provider may own multiple homes and there may be management problems and gaps in coverage by qualified staff.

VALUE OF THE OMBUDSMAN VISITS:

- Licensors only visit an average of every 12-15 months; there may be no complaint investigations by the Department since none were called in. There is no substitute for an advocacy presence in a care setting.
- Knowing someone cares about your welfare is important for a resident that may feel isolated.
- Ombudsmen have a special focus that includes rights and quality of life issues that may be overlooked by family, friends, and licensors.
- When an ombudsman establishes a good relationship with a provider, they may be willing to listen and care problems can be addressed early.
- Ombudsmen are able to negotiate between the provider and residents and can help when there are resident-to-resident conflicts. Licensing staff do not do this.
- Critical situations can be recognized and resolved or referred to outside agencies for resolution.

JOINT EFFORTS TO RAISE STANDARDS:

- Adult Family Homes grew at an explosive pace in the mid-late 1990's. Standards were minimal and enforcement of those standards was inconsistent in part because the state case managers who placed residents in homes were also the licensors.
- The licensing activity was moved from the division in Aging and Disability Services Administration to the division that surveyed nursing homes (Residential Care Services). This change came about in part because of reports by the LTC Ombudsman Program regarding abuse, neglect, and poor standards in AFHs. At this time a distinct split was made between case management and licensing to remove conflict of interest. Licensors now focus on the AFH standards of care, service, and physical environment while case managers focus on resident assessment and appropriate placement.
- The Long-Term Care Residents Rights Law, written in part by the ombudsman program, was passed. Now residents in licensed community settings had rights similar to those in nursing homes.
- Adult family homes must meet additional requirements to be designated as specialty homes and care for persons with special needs such as mental health, dementia, and developmental disabilities following the proper training.
- Training requirements were added to improve the quality of care. Current requirements include:

- Orientation - prior to routine care giving
 - First Aid and CPR – prior to care giving alone
 - Basic training & modified basic training (fundamentals of care giving).
Providers- prior to licensing; caregivers -120 days
 - Manager mental health, dementia and developmental disabilities specialty training - prior to caring for those residents or within 120 days of a current resident developing special needs.
 - Caregiver specialty training – no timeline because they are trained by the provider
 - Residential Care administrator training will be required of AFH owners prior to obtaining a license.
 - Nurse delegation training - prior to the delegating process
 - Continuing education - annual requirements of 10 hours.
- The use of physical and chemical restraints was greatly restricted. The WAC only allows their use when medically indicated and a nurse or physician must be present to use physical restraints. Assessments must be done to assure proper use of chemical restraints.
 - AFH requirements now include an assessment prior to resident admission and when there is a significant change in condition, or if none, than at least annually. This is to be done by a nurse, physician, or social worker with a degree and experience in the field, or a state case manager. An approved model assessment tool is available to AFH providers and assessors.
 - Nurse delegation and medication assistance:
Formal nurse delegation was a major change in community settings. It brought an RN into settings to delegate tasks to unlicensed but trained staff. RNs can now delegate all nursing tasks except sterile procedures, injections, and central line maintenance.
 - The laws on medication assistance spelled out when the unlicensed caregiver could assist the resident in self medication of drugs using certain guidelines.
 - Nurse delegation is specific to each resident and all caregivers who wish to provide delegated tasks must be trained by an RN. If there is caregiver turnover, the RN must return to train new staff on delegated tasks. This can become an expensive service for private pay residents if turnover is constant.

STANDARDS USED IN ADULT FAMILY HOMES:

- Laws – Regulatory Code of Washington (RCW)
 - RCW 70.128 Adult family homes
 - RCW 70.129 Long term care resident rights
 - RCW 74.34 Abuse of vulnerable adults

- Regulations Washington Administrative Code (WAC)
 - WAC 388-76 detail requirements in adult family homes
 - WAC 388-112 Training requirements

LEARNING ACTIVITY #1 – FACILITY FEUD GAME

SEE PAGE 40

The purpose of this activity will be team learning on how to access the regulations using excerpts from WAC 388-76-Adult Family Homes and WAC 388-112 Residential Long-Term care services (training requirements).

WHO REGULATES AFHS:

Currently Aging and Adult Services Administration is divided into four divisions.

1. Residential Care Services (RCS): This division does the licensing and complaint investigation.
2. Home and Community Services (HCS): This division does placements, assessments, and case management of Medicaid clients. They are also in charge of the training programs
3. Management Services: This division makes the payments to the providers.
4. Developmental Disabilities: This division does placements, assessments, and case management of persons with a developmental disability.

HOW AFHS ARE REGULATED:

The Residential Care Services Division of Aging and Disability Services Administration regulates AFHS using:

- Inspections: Licensors inspect the home prior to licensing the home and at least every 18 months. They determine compliance with laws and regulations. They also do follow up visits to verify correction of deficiencies.

Licensors do unannounced visits to look at environmental issues as well as the care in the home. They have a structured process that involves observations, interviews, and record review. They may write citations and recommend enforcement action. They also do follow-up visits to verify correction.

- Complaint Investigations: All complaints called into the hot line are prioritized in headquarters and assigned to the RCS field offices for investigation by RN investigators. A complaint investigation is a type of inspection but with a narrow focus on a particular problem. The purpose of the visit is not to resolve complaints but to investigate and determine if there are violations of the laws or regulations.
- Enforcement Actions: The purpose of enforcement actions is to force the provider to correct identified violations of laws or regulations. Actions include civil fines, conditions on licenses, stop placements, license revocation/suspension. Sometimes the only way to protect residents is to suspend the license and move residents to another setting. There are limitations to using only enforcement to improve quality of care.

WHY YOU NEED TO KNOW THIS:

- You need to understand what the licensors and investigators are looking at and that the purpose of their visit is evaluating compliance with regulations.
- It always helps to “speak the language” when you turn in a complaint to the Department. It is helpful to know what they look at and to be able to frame your notes accordingly.
- Licensors are a good source of information on regulations and facilities.
- Licensors are the pathway to enforcement; ombudsmen have the power of persuasion.
- Shared information and working together enhances the life of the resident.
- You may be asked to do a resident rights training for a provider as a part of their plan of correction.
- Ombudsmen need to understand the licensing program so they can identify possible system problems in the licensing process.

OTHER FACTS ABOUT LICENSING:

- Licensing staff (licensors and complaint investigators) do not need the resident's consent to read records. They have more latitude about not getting a resident's consent before proceeding with an investigation or action. All department staff are mandatory reporters.
- The purpose of these visits is to determine compliance with state laws and regulations, not to resolve complaints. They do not negotiate or problem-solve with providers or for residents, but can refer those situations to ombudsmen.
- When licensing staff visits, they are looking for a failed practice by the licensed provider that is related to regulations. This occurs during inspections as well as complaint investigations. They use observation, interview, and record review to determine the scope and severity of the failed practice and determine the outcome (or potential outcome) to the resident(s).
- A statement of deficiency (SOD) is written (consists of written citations), and the provider must write a plan of correction
- A follow up visit is made to insure correction.

- Enforcement actions such as civil fines, stop placements, conditions on licenses and license revocations/suspensions may be imposed as a result of serious violations or non correction.

UNDERSTANDING CITATIONS

WHY DO YOU NEED TO KNOW HOW TO READ A CITATION?

- You need to understand how to read citations in a statement of deficiency to know what problems are present in a facility, how prevalent they are and how serious a problem to the residents.
- If asked to provide an in-service on resident rights for an AFH as a part of a directed plan of correction by licensing you need to understand the specific problems in the violation.
- You can provide follow up to a written citation.

A written citation includes the following components:

- Statement of the requirement and failure to meet statement;
- Statement of the scope and severity;
- Statement of outcome or potential outcome;
- Supporting evidence (observations, interviews, record reviews. the who, what, when, where, and how of the deficiency.

The priority of significance in evidence gathering is in this order.

- Observation (of residents, staff, and environment) is most powerful;
- Interviews (resident first, family, provider & caregivers) are second;
- Record review is last. (particularly unreliable in AFHs)

LEARNING ACTIVITY #2 – READING CITATIONS- PAGE 42

MODULE II

ADULT FAMILY HOME VISIT

GUIDELINES

MOTIVATING THE PROVIDER

"One issue I have identified is that there really isn't any reason for any of my homes to be great, they just have to meet the minimum requirements."
Glory Haga, Regional Ombudsman - Grays Harbor and Pacific Counties.

Things to remember:

Remember that the day-to-day ombudsman power lies in influencing care providers to do their best to give good care. Certainly you can refer it to the licensing agency, but unless the problems are serious and/or uncorrected, you will want to resolve it at the lowest level with the provider.

Your power is in your knowledge of the resident rights laws, your ability to communicate with residents, their families and AFH staff, and your skills in building relationships. This foundation will aid you in problem solving as well as in your skills of observation, interviewing and reviewing records.

"My philosophy is that I start with the premise that the person (provider) chose to do this job and that they want to do a good job."
Linda Kelly-Regional Ombudsman, Clark, Skamania, & Klickitat counties

Some Considerations:

- Although AFH providers can vary in their skills, education, ethnicity and experience, some AFH owners may not be sophisticated and don't leave you guessing about their thoughts or feelings. This can be refreshing, but this direction of communication can get a little emotional and sometimes hostile.
- There are some strong anti-government feelings out there. Make it clear that you don't work for the licensing agency. You may have to say it more than once. Also carrying a briefcase with laws/regulations which you share will send a message that you are "government".
- They absolutely respond to positive feedback and will work hard to please you if you have established a good relationship.

- Treat them with respect as a professional. That is how they think of themselves.
- In giving feedback, use a positive approach. Instead of just stating "You didn't do a very good job in the care plan," try saying "I know you know what needs to be done for Mr. Henry; did you forget to include it on the plan?"
- Always make it about the resident, how a poor practice may affect the residents. Keep it from being personal to the provider. It is hard to do this in this kind of a setting.
- Remember, often good people can be responsible for bad things. Treating them like bad people gets you nowhere.
- Avoid quoting WACs, etc. That's not your area of expertise. Certainly asking them if they have the regulations is appropriate. Let them look up the regulation and you can discuss it together.

Opportunities for Building Relationships:

- RCS Orientation for prospective AFH owners:
Regional Ombudsmen typically attend this RCS Orientation for new providers to give an overview of the LTCOP and resident rights. Regional Ombudsmen experience finds that this is an excellent time to begin to establish relationships. It's on neutral ground and they are new and open to anyone who can offer help in working with residents. When you then make your first visit to the home, the LTCOP is familiar to the provider and this will help reduce their anxiety or perhaps suspicion.
- Provider Association meetings
There may be opportunities to attend local chapter meetings to meet providers and educate those regarding resident rights. This would count as continuing education for providers, which is always in demand. There are two associations: the Adult Family Home Association and the Washington State Residential Care Council.
- One provider group staged a "street of dreams" like event where the community, including local politicians, were invited to educate the community about adult family homes. A local ombudsman could encourage such an event and attend.

The provider should be encouraged to invite members of the community into the home for special occasions as well as seek out opportunities for residents to participate in community activities. The ombudsman can support these efforts by letting them know about community activities.

I believe in involving the community in quality, contact your city management to bring them into your efforts.

Vickie Elting-Regional Ombudsman King County

ADULT FAMILY HOME VISITS

PRE-VISIT PREPARATION:

- Pull the file and review for previous problems in the home. Regional Ombudsmen will give what data they have to the volunteer who is visiting.
- Regional Ombudsmen try to routinely meet with RCS staff to determine which homes might benefit from an Ombudsman visit in order to help the Ombudsman staff prioritize their assignments.
- If not provided by your regional ombudsman, ask for directions or go to a search engine such as Mapquest for directions.
- Be sure to take the consent form for release of information.
- Keep plenty of brochures on hand.
- For safety considerations, if at any time you feel physically threatened by a provider, caregiver or resident, you should immediately leave the home and call your supervising ombudsman.

INITIAL VISIT:

- On a first visit, you will want to gain certain information about the home. Please consider that it is not necessary to get all this information on this visit. You are there to talk to the residents, establish a relationship with the provider, and lay the groundwork for your work with the resident. You can complete your data on the next visit(s).
- This is a get-acquainted visit. Whether you are an ombudsman, licensor, or complaint investigator, it benefits you to behave as a guest in their home. For example:

Rather than telling the provider you want a "tour of your facility", ask them if they would "please show me your home".

Quote by unknown Washington State licensor

- Knock on door; wait for provider to appear before coming in past the entry area. There are exceptions if you find residents alone, etc.
- Wear your badge and present ID to the provider. Explain your role as an ombudsman and that the laws require that you visit residents in adult family homes. State that you do not work for the state licensing or placement agency. Offer a program brochure.

- State that your role is different from the licensors and that you are there to visit with the residents. Explain that residents typically enjoy an outside visitor and that we are an extra resource to support the residents if they have any questions or need assistance in some way.
- It is a good time to let them know how you can help them in working with their residents. Explain that your job is to help them as providers to improve care of the residents. Share that sometimes outside eyes can sometimes see a different way.
- This may a good time to ask to see their latest written report by the licensors or complaint investigators. If the provider is fearful or hostile, wait until he/she relaxes or wait until the next visit.
- Try to avoid the “clipboard and check-off list” scene in the interview with the provider. You don’t need to get all the information about the AFH on the first visit. Think “building a relationship” at this point.
- Lay the groundwork for future private meetings with residents, explain the need for privacy and ask how they can help you accomplish this. Ask what areas could be made available in the home when you visit. Explain to the provider that your private conversations with residents must remain confidential.
- Explain that you will need contact numbers for family members, that contacting them is a part of your routine process. See Attachment #5 for authority.

RESIDENT OBSERVATION AND INTERVIEWS:

“Everything you really need to know is in RCW 70.129 (the Long-Term Care Residents Rights Law).”

Rose Floyd-ombudsman, King County

- Introduce yourself and explain that you are a long-term care ombudsman. State that you are a volunteer, that it won’t cost them anything and you will be visiting on a regular basis. Explain that, with their permission, your job is to make sure they know their rights. Explain that you will help them with problems in the home.
- Greet each resident and spend at least five minutes with each. Do observations & interviews as suggested on Attachment #2. Select at least one interviewable resident to do a more in-depth interview using the suggested interview questions. You may need to contact family members/surrogate decision makers in lieu of interviewing a resident. See ATTACHMENT # 2. Identify the presence of resident problems and use your skills to problem solve with the resident.

The most important skill for an ombudsman to have is the ability to problem solve on behalf of the residents.

Robin Low-Ombudsman, Snohomish County

- Be alert for any evidence of abuse or neglect. (See Attachment #2.)

See learning activity #3 Skill practice on interactions with providers - See Page 44

Interviewing Provider and staff

When interviewing providers or staff consider the difference between interrogation and interviewing as outlined on the following page.

Interview versus interrogation

Interview/Dialogue/Opening Communication	Interrogation/Debate/Closing Communication
Purpose is to gather information. This requires listening and clarifying	Purpose is to get a confession. The interviewer is focused on rebutting the statements of the person being interviewed.
Non accusatory—hear their position	Accusatory—defend your position.
Free-flowing	Structured.
Interviewer speaks 5% of the time. Explore information.	Interviewer speaks 95% of the time. In a debate the information is known, and the interviewer gives information and answers questions.
State what you hear check it.	Assume you know what he/she means
Think more or less without evaluating	Think “either/or” and find one best way
Share information. Accept and disclose views.	Give advice on what’s best. Evaluate each other’s views.
Respect differences	Overcome objections
Ask “What happened, and how can we?” questions.	Ask “Why don’t you”. Questions.
Strive for mutual gain	Strive to win
Build relationships to create ongoing benefits.	Make points now to build your track record.

Routine Visit

A minimum of quarterly routine visits is advisable, depending on the amount of volunteer time.

"I think it's good to have a minimum number of visits per year but my experience tells me that some homes will definitely need more frequent visits than others. That needs to be considered when you have limited time.

Linda Petrie – Regional Ombudsman - Spokane County

In addition, consider the following:

- You need a minimum of an hour each time you visit a home to get a feel for relationships and care provided.
- For routine visits, vary the visit time during typical daytime hours. Be mindful of meal times that can be busy for the provider. However, after you get to know the home and the routines, continue to vary your visits and try to observe meals and activities when possible. Late night visits must have prior approval of the state ombudsman.
- When visiting residents, use Attachment #2 for suggested observations and interview questions. Also, consider the significance of how you ask your questions. Open-ended questions gather more information. Review document titled "Interview versus Interrogation" on page 26.

Open-ended Clarifying Questions:

They begin with how, what, or why and are used to clarify information and keep the conversation open by encouraging a person to share as much as they wish.

Closed Questions:

They result in a simple "yes" or "no" in short, factual answers. They tend to bring the conversation to a stop, requiring more questions to get the full story.

**Learning activity #4A skill practice open ended questions See page 47
#4B more skill practice (optional)**

COMPLAINT VISIT:

Investigation:

Follow investigation process in ombudsman manual.

- Remember, you must first get permission to proceed from the resident or the resident's surrogate if appropriate.
- It may be difficult to gather information in this setting. Always talk to the complainant first. Try to pin down dates, times, and possible witnesses.
- In addition to your usual preparation, before you leave your office, draft a plan on how you will do your investigation. The plan should include the issues to be focused on and how you will proceed.
- For example, using the scenario under document referral page--- to draft a plan, consider the following actions for your plan:

Get as much information from the complainant. Suggested questions are about how he/she gained the information (observation or from another person) Find out as much detail as you can about the residents. Ask if they know about the staffing. (especially at night)

Go to the ADSA website and determine that the home is licensed.

When you enter the home, following a brief introduction of yourself to the provider, ask the provider to show you her home and quickly count the residents you can see.

Identify beds that appear to be occupied. Try to match residents you see to beds.

- You may need to revise your plan as you gather information, for example:

You may need to determine evacuation capability. Talk to the residents to determine mental ability. Ask Mr. James about navigating the stairs and if he needs help and Ask provider about staffing for evacuation.

- A plan is a good starting point and avoids what is called "fishing expeditions", where you lose your focus and gather too much information, often much of which is not useful or pertain to the complaint issues and you can drown in information. Talk to your supervising ombudsman for advice in writing your plan.

- Try to visit at different times of day pertinent to the complaint.
- Finally, realize that you may miss something. It is distressful, even to the most experienced ombudsman, licensor, or complaint investigator to have been at an AFH for several hours and then find out another party was in the same home a few days later and came up with some horrendous findings.

It has happened to all of us. There is often a good reason you didn't find this problem. And a serious problem will surface sooner or later. You still need to trust your instincts.

- The resident or resident surrogates may not allow you to proceed with the investigation or want to do it themselves. Schedule a revisit in the near future, sometimes a relationship must be established before your investigation will be allowed. Contact your supervising ombudsman.

"The resident is the boss" and "Hands off" meaning anything that anybody else can do for the resident, we don't"

Paul Tosch-Regional Ombudsman-Lewis/Mason/Thurston Counties

FOLLOW UP VISIT:

Verifying resolution of issues:

Generally a follow up visit is limited to the specific problem identified on a previous visit. Use visit guidelines found on First visit page 14 as appropriate to the issue.

In an adult family home setting, it's hard not to see other things that need addressing. Sometimes it is more practical to complete looking at the follow up issues prior to starting a new investigation or even returning to the home to investigate the new issues.

Document the status of issues and any actions/referrals you make.

"Nothing will "sink" your program as fast as a failure to do follow-up visits to verify if a problem has been corrected."

Kary Hyre, Former State Ombudsman, Washington State

DOCUMENTING YOUR VISIT FOR REFERRAL TO LICENSING:

Required Information when a LTC Ombudsman makes a referral to The Abuse and Neglect Reporting Hotline- Complaint Resolution Unit (CRU).

Questions to ask yourself before you make a referral:

- Do you have consent from the resident or representative if the resident can't speak on his/her behalf?
- Is there a more appropriate person to make the call such as the resident or family directly?
- If staff reports a suspected abuse or neglect situation to you have they reported it as a mandatory reporter as required by law?
- Have you consulted with your regional ombudsman?

When making a referral includes the following information:

- Name and address of Facility
- Name of Ombudsman and phone number and address of Regional Program

Description of event(s) including:

1. Date and time of the event: _____
2. Location in the facility: _____
3. Name of resident(s) involved (with permission) Room # and bed

Describe the nature of the complaint including any facility staff involved:

What law or WAC do you think was violated? Be as specific as possible.

Name and phone number of any other persons who can verify the complaint.

Instructions to CRU regarding follow-up:

Does the resident or representative want to be contacted directly by the Complaint Investigator?

What is the best way to contact?

Where should reports be sent to? The resident? The Ombudsman?

After calling or faxing the complaint:

The CRU office staff will call you or the Regional LTCO with the Control Number. This is your best way to track the complaint through the Residential Care Services Complaint System.

This case must be entered into Ombudsmanager. Once the final report is obtained, you can determine with the complainant if they are satisfied with the outcome or not.

Example of Completed Referral Form:

Required Information when a LTC Ombudsman makes a referral to The Abuse and Neglect Reporting Hotline, Complaint Resolution Unit (CRU).

Questions to ask yourself before you make a referral:

- Do you have consent from the resident or representative if the resident can't speak on his/her behalf? **Yes**
- Is there a more appropriate person to make the call such as the resident or family directly? **Resident requested that I call on her behalf**
- If staff reports a suspected abuse or neglect situation have they reported it as a mandatory reporter as required by law? **N.A.**
- Have you consulted with your regional ombudsman? **Yes**

When making a referral, include the following information:

- Name and address of Facility:
Happy Acres Adult Caring Home
1111 E. Columbia
Yakima WA 98053
- Name of Ombudsman and phone number and address of Regional Program:
Louise Ryan
PO Box 23699
Federal Way WA 98093
(800) 422-1384

Description of event(s) including:

- Date and time of the event: January 5, 2003
- Location in the facility: N.A.
- Name of resident(s) involved - Jane Jones

Describe the nature of the complaint including any facility staff involved:

Jane received a discharge notice on January 2, 2003, which stated that the facility could no longer provide her care due to an increase in seizures, increased documentation and coordination with doctors, the frequency of her urinary tract infections, and associated increased staff time related to her care needs. Jane has paraplegia as a result of a car accident and has lived at Happy Acres for the past year. She was admitted to the facility with the same needs she has now one year ago.

Jane states that her Home Health Agency monitors her in-dwelling catheter and changes it monthly. She still has the ability to monitor her own care needs and coordinate with her doctor. She is in constant communication with her doctor and nurse and is physically able to take her own medications with assistance from her son who sets up her pill box every two weeks.

Jane contends that her seizures are no different than before and that staff turn-over has added to her care problems. Jane is currently paying \$5,500 per month and is willing to purchase additional services from the Home Health Agency to resolve the impact on staff, but the AFH owner, Kathy Kape, will not assist with this plan.

What law or WAC do you think was violated? Be as specific as possible.

I believe that the discharge notice is not valid because the facility did not attempt to provide reasonable accommodations prior to issuing a discharge notice. See 70.129.110(3) (a).

The administrator has not attempted to coordinate services with Jane's outside providers and has not assigned consistent caregivers to learn Jane's care needs. Jane provided full disclosure of her complex care needs at the time of admission one year ago and has lived successfully at the facility for the past year.

Name and phone number of any other persons who can verify the complaint.

- Her son, Tom Jones, at (509) 656-7144
- Her Physician, Dr. Lane, at (509) 665-8876
- Home Health Agency Social Worker, Penny Lucky, at (509) 676-9900

Instructions to CRU regarding follow-up:

Does the resident or representative want to be contacted directly by the Complaint Investigator? **Yes – Contact Jane directly at the facility or call her at (509) 555-1234.**

Where should reports be sent? **Please send the final report to Jane at the facility and to Louise Ryan at the above address.**

After calling or faxing the complaint:

The CRU office staff will call you or the Regional LTCO with the Control Number. This is your best way to track the complaint through the Residential Care Services Complaint System.

This case must be entered into Ombudsmanager. Once the final report is obtained you can determine with the complainant if they are satisfied with the outcome or not. Ombudsmanager Case number YK200300030

ATTACHMENTS

ATTACHMENT 1 - ADULT FAMILY HOME VISIT GUIDELINES

ATTACHMENT 2 - SUGGESTED OBSERVATIONS AND INTERVIEWS

ATTACHMENT 3 - SELECTED TOPICS

ATTACHMENT 4 - WORKING WITH INTERPRETERS

ATTACHMENT 5 - ACCESS TO RESIDENT REPRESENTATIVES

ATTACHMENT 6 - WAC 388-76 - EXCERPTS

ATTACHMENT 7 - WAC 388-112 - EXCERPTS

ATTACHMENT #1 – ADULT FAMILY HOME VISIT GUIDELINES

Your visit may or may not follow the flow of this document. You need to respond when opportunities for observations or interviews present themselves.

Date of Visit(s): _____ AFH Name: _____
Date First Licensed: _____ Address: _____
Owner's Name: _____
Resident Manager's Name: _____
Specialty Home (designate): _____
How nursing services are provided if needed: _____
Staffing:
24-hour awake staff Yes _____ No _____
Number of staff hours per day (including provider only if caregiver) _____
Licensed Capacity _____ Current number of residents _____
Current license is displayed Yes _____ No _____
DSHS/Ombudsman Poster Yes _____ No _____

PART A – CONTACT WITH RESIDENTS OR FAMILIES

- How many residents were you able to communicate with?
- How many family members or significant others did you contact during or after visit?
- Any recurring themes in resident interviews?

PART B – OBSERVATIONS OF RESIDENTS AND STAFF (see guidelines on Attachment #2 for suggested observations and interview questions)

- Where were the residents located when you entered and during your visit?
- How did the residents appear? (e.g., clothing, personal hygiene, bruising, skin tears, signs of dehydration, weight loss) See Attachment 2 – Observations & Interviews
- How do residents respond in interaction with staff and with you? Are there language barriers between resident and staff? Do you have difficulty communicating with staff? Is it a problem for the residents?

ATTACHMENT #2 – SUGGESTED OBSERVATIONS AND INTERVIEW QUESTIONS

OBSERVATIONS:

Are the residents clean, well groomed, and appropriately dressed?

Any signs of abuse or neglect? See Attachment #3 – Selected Topics.

Resident is bed bound (unless hospice).

Observation of resident-staff or resident-to-resident interactions:

Observe the following:

- How do the residents and staff respond to each other in interactions?
- Is there courtesy and respect on the part of the staff?
- Is there a prompt response to resident's requests?
- Are there language barriers between resident and staff? Or between you and staff?
- Is there conflict between residents? Is it properly managed by the provider?

Observation of physical environment:

- Is it a home-like setting with personal items of residents?
- Is it quiet? Quiet can be calming or indicates a lack of activities.
- You want to look at the physical environment and how it affects residents. For example, is ambulation capability an issue in the environment? Is there a resident in a situation where they could not exit in an emergency?
- See if there other obvious safety issues.
- Check to see if the "DSHS/Ombudsman ombudsman poster is displayed where residents, surrogates, and visitors can see it.
- Are there fluids available for residents?
- Is the resident's room clean, comfortable, and homelike with some of their possessions around them?
- Is there adequate lighting in the room?
- Note the presence of dressings in the room.
- Is the adaptive equipment clean and usable?
- Do you see any tripping hazards?
- Look for presence of bed rails or other restraints such as geri chairs, seat belts or locks on outside of bedroom doors.

INTERVIEWS:

Try to find a private place for your interview. Ask the resident if he/she is willing to talk to you. Let the resident guide the conversation at first. If they are reluctant, start by commenting on his/her pictures, possessions, or the weather. Try to find a common interest to talk about to put the resident at ease. You then guide the conversation to your interview questions.

After a few questions, you may begin to focus in on some areas of concern. Remember, open-ended questions produce more information. Do a lot of follow up questions if the resident's response concerns you or is vague or unclear. If the resident gets tired or anxious, stop and talk to another resident and attempt to come back to finish the interview.

Approach the interview in an unbiased manner. Don't ask leading questions. You want to get the facts about what happened. You shouldn't start with a hypothesis and try to prove it. This slants your investigation. Be as neutral as possible in asking your questions. You want to interview not interrogate.

Sample Interview Questions:

You don't have to use all or any of these questions, they are suggested topics and questions. You may use which ever seems to fit the discussion.

Food

- How is the food? Do you get enough? Can you have seconds?
- If you don't like what is being served for a meal, what happens?

Choice

- What is your usual routine here?
- Do you have any choice in when you get up and when you go to bed?
- What activities do you like?

Privacy

- When you want to make a private phone call, or have a private visit, how do you do it?
- Do you have privacy during your care?

Home conditions/rules

- Do you know what the house rules are?
- If you don't get along with your roommate, what can be done about it?

Finances

- Who handles your money?
- Can you access your money when you want to?

Health care services

- When you need to see your doctor how is that arranged?
- How are your medications managed?
- Do you have a say in your health care?

Sense of well being

- Do you feel safe here?
- Do you like your caregivers?
- If you have a complaint, what do you do?
- Do you feel respected?
- Is there anything about living here that you would like to change?

Family or Surrogates Interview Questions:

- How do you feel about the care being provided?
- What are some things you like about this home?
- What are some concerns you have had about this home?
- Do you feel the residents rights are respected in this home?
- Are you able to visit the resident privately in the home?
- What would you change about this home?

ATTACHMENT # 3 – SELECTED TOPICS

COMMON SIGNS OF ABUSE AND NEGLECT:

- Does resident fit profile for “more likely to be abused” (cognitively impaired, aggressive, hard to care for, and may be physically helpless).
- Bruising, unexplained or in unusual places. The family is also a good source. Discuss the bruise with provider. Is the explanation reasonable? You may have to bide your time. It’s very difficult to make a case in this environment.
- Fearfulness around staff. Look for this to manifest around certain staff persons.
- Signs of physical restraint use are the presence of full bed rails (may fold under the bed), geri-chairs, locked recliners and door locks. You may also see posey vest restraints, soft wrist ties, or even burn marks on wrists.

Physical restraints can only be used with a nurse or physician on the premises.

SKIN, TEARS, AND OTHER INJURIES:

- Signs of chemical restraints are appearance of over sedation (excessive drowsiness), shuffling gait, facial grimacing, agitation, lack of interest, or seclusiveness.
- Provider is required to have assessment done for use of these medications.
- Skin breakdown is almost always a sign of poor care. Risk factors include limited mobility, dependence in activities of daily living (ADLs), incontinence, poor nutrition, poor fluid intake, and confusion. Look for dressings and ointment in the room. If you suspect skin breakdown, ask if there is awake staff at night to frequently turn residents. Residents at risk of skin breakdown require meticulous skin care and turning at least every two hours.
- Weight loss or dehydration is conditions that often go unrecognized. Risk factors include impaired cognition, dependence on staff for ADLs, depression, and language barriers. Signs are generalized weakness, dry lips, skin appears loose, eyes appear sunken, weakness, and delirium or increase of confusion.

FALLS:

The risk factors for falling are age greater than 80, poor balance, generalized weakness, arthritis, limited ability to do ADLs, cognitive impairment, and certain medical problems.

You need to find out if this fall was unexpected. Was the provider aware of a history of falling? If not, it may not be a quality of care issue. How many times has the resident fallen? Did the provider promptly ask for an assessment to better protect the resident? What was done to protect resident? What is on the care plan? (Note: No restraint use except under certain circumstances.)

RETALIATION—STAFF PERSON:

Retaliation is a very real issue. Staffs have been terminated because they talked to an ombudsman or department representative. We cannot guarantee it will not happen. Offer to meet them away from the home. Even so, in a small setting such as an AFH, it's hard to protect your sources. The facts of the situation often point to the source of the information.

I think you need to gently point out that if they know of abuse or neglect and do not report it or take any action, they become a party to the abuse or neglect. Remind them they are also mandatory reporters; they may not know that. Also, any license or certification they have is at risk.

Explain the whistle blower law to them. But the bottom line is that you cannot promise to protect another person from retaliation. All you can do is assure them of confidentiality unless a legal situation results from the information given to you.

RETALIATION—RESIDENT OR SURROGATES:

When a staff person worries about retaliation, they worry about losing their job. For a resident it can be more frightening. They have a concern about being abused mentally or physically for talking to someone. They know they may be left alone with a potential abuser who is angry, particularly if the abuser is the provider.

You can share the laws about retaliation and not wanting it to happen to another resident, but unless they feel safe; it will be difficult to gain the information you need.

It may take more than one visit to build trust. The resident's family will also worry about that. Sometimes, the only way to get the resident or family to open up is after the resident has moved to another setting where they feel safe.

THE MEDICATION PROCESS:

When a resident is admitted to an adult family home, an assessment by a practitioner (physician or more commonly a nurse) must be done to determine the resident's functional status regarding medications. They may be determined to be independent, need assistance, or need administration of medications.

- Independent with self-administration:

The resident is independent with storing and taking his/her medications. He/she requires no assistance.

- Self-administration with assistance:

This is where an unlicensed caregiver assists a resident take their prescribed or OTC medication or treatment. The resident must be able to place the medication in their own mouth or instill it, although the caregiver can guide or steady the hand. They need to understand they are taking a medication. They don't need to know anything more about the medication. The medication cannot be left with the resident.

- Medication administration:

This is where the medication is given either by a licensed nurse (RN or LPN) or an RN can delegate the administration using a certain protocol. Each delegated caregiver must be trained individually for each resident. Ongoing assessment is required for delegation.

AUDIO-VIDEO USE:

The only places video cameras are allowed are at exit doors for safety. Auditory monitors (baby monitors) can only be used with the resident's knowledge and consent.

Discharge and reasonable accommodation:

The law says that a resident may only be discharged for certain specific reasons. That is, if it is necessary for the resident's welfare, safety or health of individuals is endangered payment issues and closure of facility.

Reasonable accommodation in this setting may be different than in a larger care facility. For example, if the issue is lack of staffing needed by a heavy care resident, it may not be reasonable to expect a small facility to hire another staff person.

In some ways the issue is treated the same. For example, if the resident's issue is behavioral or related to mental health issues, the provider is expected to get a mental health evaluation prior to discharging the residents under the "the resident's needs cannot be met" caveat. Depending on circumstances, the 30-day notice may or may not apply.

How You Can Use The Care Planning Process:

The provider is required to do a negotiated care plan in collaboration with the resident or resident's surrogate within 30 days of admission and changed as the assessment changes.

If you have identified a conflict or communication problem, this is an opportunity to offer to assist in resolution of the problem you have identified. It would be entirely appropriate for you to suggest a care planning meeting with the resident and/or surrogate, the provider and yourself. Once you have a successful resolution, this may greatly enhance your relationship with the provider while improving life for the resident.

ATTACHMENT #4 – GUIDE TO WORKING WITH INTERPRETERS IN HEALTH SERVICE SETTINGS

How can you tell if an interpreter is required, especially if the person can speak some English?

Some people can't communicate in English at all or will have such minimal English proficiency that the decision is obvious. Some will bring an 'I need an interpreter' card. However, if there is any doubt, here are some simple tests to help you make your decision.

- Ask a question that requires the person to answer in a sentence. Avoid questions that can be answered with a 'yes' or 'no' or a very familiar question such as 'where do you live?'
- Ask the person to repeat a message that you have just given in his/her own words.

If you consider an interpreter is required then arrange one after discussing this with the client. Remember the interpreter is there to enable you to do your job competently, not only for the resident.

How do you do face to face interviews with an interpreter present?

Before an interview:

- Arrange a place where the interview can be conducted in private.
- Allow for extra time.
- Arrange the seating to allow for easy communication; in a circle or triangle or place the interpreter to the side and just behind you.
- Brief the interpreter prior to the interview where possible.
- Ask the interpreter for any cultural factors that may affect the interview but remember that interpreters do not consider themselves to be cultural experts.

General pointers:

- Sit facing the resident.
- Look at the person and maintain awareness of body language. Avoid looking at the interpreter unless you are directly addressing him/her.
- Speak directly to the resident as you would with an English speaker.
- Always use the first person; e.g. how are you feeling? Not (to the interpreter) ask her how she is feeling?
- Don't try to save time by asking the interpreter to summarize.
- Be aware that it may take more words than you've spoken to convey the message.
- Don't let the interpreter's presence change your role in the interview. It is not the interpreter's role to conduct the interview.

Introduction and setup:

- Introduce yourself and the interpreter.
- Explain both your and the interpreter's role.
- Stress that both you and the interpreter are bound by codes of ethics to maintain the confidentiality of the interview.
- Explain the purpose of the interview and how it will proceed.

Interview style:

- Speak a little more slowly than usual in your normal speaking tone. Loud doesn't help.
- Use plain English where possible
- Pause after two or three sentences to allow the interpreter to relay the message.
- Stop speaking when the interpreter signals by raising a hand or starting to interpret.
- Summarize periodically when complex issues are involved.
- If the person does not understand, it is your job (not the interpreter's) to explain more simply.
- Seek the resident's permission if you need to obtain cultural information from the interpreter.
- Avoid long discussions with the interpreter. If you need to talk to the interpreter, the interpreter should explain that to the resident.

Ending the Interview:

- Check that the resident has understood the key messages in your interview. Ask for any questions.
- Thank both the resident and the interpreter. Say good-bye formally.
- Debrief the interpreter if the interview was emotionally taxing and clarify any questions you have arising from the interview. This may need to happen later as it may make the resident uncomfortable if you are seen to be in a detailed conversation with the interpreter.

ATTACHMENT #5 – ACCESS TO RESIDENT REPRESENTATIVES

Ombudsmen have the duty to inform residents and their representatives and others about resident rights and about how to obtain services. RCW 43.190.060

Long-term care ombudsmen have several duties that require access to the residents and their representatives of family members. If the ombudsmen are not given the names, addresses, and phone numbers of the resident representatives or family members, then it is impossible to contact these people and the ombudsmen cannot fulfill their duties. Several of our duties require active outreach by the ombudsman. Ombudsmen have the duty to:

- Inform residents, residents' representatives, and others about the residents' rights. RCW 43.190.060(3)
- Identify, investigate, and resolve complaints made by or on behalf of residents. RCW 43.190.060(1)
- Ensure that residents have regular and timely access to ombudsman services. 42 USC § 3058g(a)(3)(D)
- Provide support for the development of resident and family councils. 42 USC § 3058g(a)(3)(H)

The State must ensure that ombudsmen have access to all long-term care facilities and residents. 42 USC § 3058g (b) (1) (A). Under state law, ombudsmen have unrestricted, private access to residents any time required to investigate or monitor a matter. WAC 365-18-100(1). If the resident is mentally incapacitated, then for purposes of exercising rights and decision-making state law considers the resident's representative to be the "resident". RCW 70.129.010(4). Therefore, the ombudsman has unrestricted access to contact information about the representative of an incapacitated/incompetent resident.

Ombudsmen have the right of unrestricted access to long-term care facility residents. RCW 70.129.090(1) (c)

Question: Can the Adult Family Home Provider give the name of the resident's representative to the ombudsman without violating the resident's right of privacy?

Answer: Such information must be given to the ombudsman if the resident is incompetent (and thus cannot consent) or is unable to communicate. In these circumstances, the ombudsman must have access to the representative in order to ensure that the resident is informed of their rights. Withholding the representative's name, address and phone number would impede the ombudsman's duties.

Furthermore, a policy that the representative would be contacted and asked if he or she wishes their identity disclosed, would also impermissibly interfere with the ombudsman, since it would inherently intimidate some representatives and stifle contact with the ombudsman. Willful interference with ombudsmen in performance of their official duties or discriminatory or retaliatory actions against an employee, resident, or any other person for disclosing information to an ombudsman is illegal and may lead to a civil fine. RCW 70.128.150

Summary of ombudsman visit:

"There will come a time when you feel comfortable in your ombudsman shoes, but you will never know everything there is to know because each situation and resolution is as unique as each resident we serve."

Michal Glauner, Regional Ombudsman – Snohomish County

HAND OUTS FOR ACTIVITIES

HANDOUT FOR LEARNING ACTIVITY #1

Question # 1.What regulation covers the situation where a resident needs physical assistance to ambulate during an emergency?

Question #2. A provider asks you what the regulations say about leaving a resident alone on the AFH. What regulation explains the requirement to you?

Question #3. You go to an AFH and discover a sliding lock on the door of a resident's room. You suspect he is being locked in his room. What regulation addresses this issue?

Question #4 what other WAC applies in the situation in Question #3?

Question #5 during your visit to an AFH, a resident tells you that his nephew comes and takes all his money and he doesn't like it. What regulation addresses this issue?

Question #6 A care giver in an AFH asks you if she sees another care giver hit a resident, is it enough for her to report it to the provider? What regulation gives direction in this situation?

Question #7 you enter an AFH and find a caregiver overwhelmed and on the verge of tears. She says, I just started today, have no training, don't know the residents and hasn't even been orientated to the home. What training is required before a caregiver can have routine interaction with residents.

Question #8 In the question #7 situation, what other WACs would apply?

HANDOUT FOR LEARNING ACTIVITY #2

Learning activity #2

Using the list of components of a citation, identify and underline the components in the following citation.

EXAMPLE OF A WRITTEN CITATION:

WAC 388-76-10805 Fire protection requirements (3) the facility must ensure that smoke detectors are in working condition at all times.

Based on Observation and interview, it was determined that the facility failed to ensure that three of four detectors were in working condition. The facility failed to ensure smoke detectors work in working condition placing all residents at risk of harm by fire.

At 2:00 pm on 11/6/2006, the provider was asked to test the detectors in room #1, #2, #3 & #4. The detectors in rooms #1, #2 and #3 did not function. Only the detector in room #4 functioned properly.

The provider made the statement "Oh, they haven't worked for a long time, but the residents are never left alone."

HANDOUTS FOR LEARNING ACTIVITY #3

LEARNING ACTIVITY #3

Case Scenario #1

You have entered an adult family home for the first time to make an ombudsman visit. You are wearing your badge, have presented your credentials, and explained your role.

The provider looks at you suspiciously and says, "You look like you are from the government. I just had my inspection yesterday and don't have time to mess with you now. "Don't you people ever get tired of violating our constitutional rights, this is my private home. I'll have to ask you to leave".

Response #1

You reach into your briefcase and bring out your regulations and show the provider the law regarding the ombudsman visits and you say, "The law is clear that you can be fined if you interfere with my work; please let me get started."

Response #2

You pause to get your emotional responses in check and then state, "Actually, I do not work for the government. I am a volunteer from your community. It sounds like maybe you had a difficult time with your inspection and are feeling angry and discouraged. Do you need to talk about it? Can you share your concerns with me, maybe I can help?"

Discuss the two responses and ask participants if they can think of another response to this case scenario.

Learning Activity #3

The second half of the activity has participants work in pairs and write responses to Case scenario #2 and #3. Ask them to role play the responses using different body language and tones of voice.

Participants will work in pairs and write a possible response to the following case scenarios and then role play the interactions.

Case Scenario #2

You are in an adult family home on a complaint investigation and after you greet the provider and explain the purpose of your visit, the provider bursts into tears and says "You've come to shut me down, haven't you?"

Case Scenario #3

You have finished your complaint investigation visit and as you are leaving the provider says "It was Mrs. Jake's family that complained, wasn't it? As far as I'm concerned, they can just take her home. I'm sick of it."

HANDOUTS FOR LEARNING ACTIVITY #4A

Learning activity #4A skill practice on Open vs. closed questions

Read the closed questions and create a different question that is an open question.

- New admission to the facility:

Closed: Did you like your first few days?

Open: _____

- Personal Life Style:

Closed: Do you like to go out? Would you rather just stay here?

Open: _____

- Adjusting/Fitting In:

Closed: Is everyone treating you fairly?

Open: _____

- Home Routine:

Closed: Is everything at this facility okay?

Open: _____

ANSWERS FOR LEARNING ACTIVITIES

LEARNING ACTIVITY #1

QUESTIONS AND ANSWERS FOR FACILITY FEUD GAME

Question # 1. What regulation covers the situation where a resident needs physical assistance to ambulate during an emergency?

Answer: WAC 388-76-10870 the resident's preliminary service plan and negotiated care plan must identify the resident's level of evacuation capability as defined by the following: . . .

- (2) Level 2 – resident is physically and mentally capable of traversing a normal pathway to safety with mobility aids, but unable to ascend or descend stairs without the physical assistance of another individual; and
- (3) Level 3 -- the resident physically or mentally is unable to walk or traverse a normal path to safety without the physical assistance of another person.

388-76-10820 The provider must ensure that residents who have an evacuation capability of level 2 or level 3 have their bedroom located on a grade level floor and exiting the building does not require the use of stairs, elevator, or platform lift to exit.

Question #2. A provider asks you what the regulations say about leaving a resident alone on the AFH. What regulation explains the requirement to you?

Answer: WAC 388-76-10195 the provider shall ensure that:

- (1) Enough staff is available in the home to meet the needs of each resident if residents are in the home or not,
- (2) Staff are readily available to meet resident needs if the home takes the resident out to another location and the resident negotiated care plan does not indicate it is safe for the resident to be left unattended for a specific time period; and
- (3) All staff are skilled and able to do the tasks assigned to meet the needs of each resident.

Question #3 you go to an AFH and discover a sliding lock on the door of a resident's room. You suspect he is being locked in his room. What regulation addresses this issue?

Answer: WAC 388-76-10655 (1) the resident has a right to be free from physical restraints; and WAC 388-76-10665 involuntary seclusion.

Question #4 what other WAC applies in the situation in Question #3?

Answer: WAC 388-76-10695(3) the provider must ensure that every area used by residents:
(a) has access to one or more exits and must not pass through a room, garage, or other space subject to being locked or blocked from the opposite side; and
(b) is not accessible only by or with the use of a ladder, folding stairs, or trap door.

Question #5 during your visit to an AFH, a resident tells you that his nephew comes and takes all his money and he doesn't like it. What regulation addresses this issue?

Answer: WAC 388-76-10670 the resident shall be free from abandonment, abuse, financial exploitation, neglect and involuntary seclusion.

Question #6 A care givers in an AFH tells you that she saw another care giver hit a resident, She wants to know if it is enough to just report it to the provider? What regulation gives direction in this situation?

Answer: WAC 388-76-10225 The provider and all caregivers shall immediately notify the department's toll-free complaint telephone number of any incidents involving allegations of resident abuse, neglect, exploitation or abandonment in accordance with the provisions of chapter 74.34 Abuse of vulnerable adults)

Question #7 You enter an AFH and find a caregiver overwhelmed and on the verge of tears. She says, I just started today, have no

training, don't know the residents and hasn't even been orientated to the home. What training is required before a caregiver can have routine interaction with residents?

Answer: WAC 388-112-0040 (1) all paid or volunteer staff in adult family homes that begin work September 1, 2002 or later must complete orientation before having routine interaction with residents. Orientation must be provided by appropriate adult family home staff.

Question #8 In question #7, what other WACs would apply?

WAC 388-10135 The provider shall ensure that the provider, entity representative, resident manager and all caregivers: Possess a valid first-aid and CPR card prior to providing care for residents OR within 30 days of beginning to provide care for residents, if the provision of care is directly supervised by a fully qualified caregiver who has a valid first-aid and CPR card or certificate.

ANSWERS TO LEARNING ACTIVITY #2:

Example of a written citation:

WAC 388-76-10805 *Fire protection requirements (3) the facility must ensure that smoke detectors are in working condition at all times. (The requirement is stated.)*

Based on observation and interview, it was determined that the *facility failed to ensure that three of four detectors were in working condition. The facility failed to ensure smoke detectors were in working condition placing all residents at risk of harm by fire. (Failure to meet requirement, scope and severity and potential outcome is determined.)*

At 2:00 pm on 11/6/2006, the provider was asked to test the detectors in room #1, #2, #3 & #4. The detectors in rooms #1, #2 and #3 did not function, only the detector in room #4 functioned properly.

The provider made the statement "Oh, they haven't worked for a long time, but the residents are never left alone." (Supporting evidence is stated.)

Suggested answers for learning activity #4A:

- New admission to the facility:

Closed: Did you like your first few days:

Open: Tell me about your first day. How was it? What did you do?

- Personal Life Style:

Closed: Do you like to go out? Would you rather just stay here?

Open: How did you spend your free time before admission?

- Adjusting/Fitting In:

Closed: Is everyone treating your fairly?

Open: How are you getting along with the staff? How are you getting along with the other residents?
What are your fellow residents like?

- Home Routine:

Closed: Is everything at this facility okay?

Open: How does the schedule fit in with your previous routine?
How are you managing?

