

Division of Licensing Programs

Protocol for Inspections at Assisted Living Programs

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VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

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FOREWORD TO SECOND REVISION

The inspection protocol is at the heart of a sustained effort by central and field office staff to increase consistency across the state. It also looks to the future by paving the way for greater resident participation in evaluating care and services rendered by the assisted living facilities (ALFs) in which they or others like them reside.

This second edition further refines the inspection protocol as a “resident centered” approach to determining the provider’s compliance with regulations. The focus continues to be on the provider’s ability to meet the residents’ needs through the actual delivery of care and services and not just “paper” compliance. The inspection tasks are designed with this in mind and are interconnected in order to both identify potential problem areas and verify from multiple sources any noncompliance discovered during the inspection. The components of observation and interview are further emphasized and integrated into the inspection process in this edition. Also, after having implemented the protocol since 2008, with some initial adjustments in a first revision, the Division of Licensing Programs (DOLP) inspectors have suggested some adjustments to procedures and introduced streamlined forms that will improve the implementation of the protocol and help staff better achieve its objectives for resident centered inspections. DOLP consultants and licensing administrators have listened carefully to how the protocol has been received by providers and provider associations, and have made any appropriate adjustments.

It is hoped that by continuing to conduct resident centered inspections, the Division of Licensing Programs will promote an even greater emphasis on resident centered care among providers. The degree to which it is able to achieve this will likely depend on the licensing inspectors’ ability to implement this protocol accurately, consistently, and efficiently.

The inspection is at the center of our work as licensing professionals. Its purpose is to evaluate and monitor the compliance of a provider with applicable standards for licensure. It also gives the provider the chance to demonstrate the systems in place at the facility to provide care and services to its residents. In order to achieve these goals, however, the inspector must effectively complete all the components of an inspection and employ thorough investigative techniques. This inspection protocol was created to be a guide for inspectors to assist them in the challenging task of performing an inspection.



1 The Six Components

There are six basic components of an inspection:

- **Entrance Conference** – Inspectors introduce themselves, outline the basic components of the inspection process, and ask for items they will need to conduct the inspection ([Appendices A – C](#));
- **Tour** – Inspectors walk through the building(s) directly after the entrance conference (or if alone, immediately after briefly introducing oneself) and as soon as possible after arrival in order to talk to residents and staff, observe interpersonal interactions and activities, check on food preparation and delivery of meals, and examine the physical plant;
- **Interviews** – Inspectors talk to residents, their family, and staff members to gather information about the facility’s compliance with standards, particularly those that relate to resident care and other services provided at the facility;
- **Observations** – Inspectors observe – from the moment they drive up to the building until the conclusion of the inspection – what is happening in the facility in order to assess compliance with standards. Inspectors pay special attention to the interaction between staff and residents, the execution of the facility’s internal policies and procedures, the quality and participation in learning and recreational activities, and the degree of safety and precision in medication administration;
- **Documentation Review** – Inspectors conduct a focused examination of resident and staff records, targeted on key standards and information gathered during interviews and observations; and
- **Exit Meeting** – Inspectors review the results of the inspection with the provider, listen to and discuss with the provider any disputed findings and/or comments about the inspection process, provide consultation, and request from the provider a description of the actions that will be taken to correct any violations and ensure future compliance.

Note: The inspector may be able to provide the completed violation notice for signature by the provider at the exit meeting, but if not will at least discuss preliminary findings with the provider. *SOP-304: Violation Notices and Inspection Summaries*, gives providers up to ten days of receipt to respond in writing on his portion of the violation notice (the “description[s] of actions to be taken” and “date to be corrected” columns).

Though the entrance conference and tour should take place at the beginning of the inspection and the exit conference at the end, the other components (or tasks) of the inspection need not occur in any particular order. This allows the inspector(s) the greatest degree of flexibility in order to be responsive to the unique circumstances presented during an inspection at a given facility. For example, if the inspection is being conducted by a team, the entrance conference, a medication pass observation, and the tour might all be conducted simultaneously. Whereas, a single inspector might conduct a brief entrance conference and follow it immediately by the tour. There is also no minimum or maximum amount of time required to complete any protocol component or an inspection generally. However, inspections now frequently require more than one day and the violation notice may be completed after the inspection.

The inspector(s) should be evaluating at all times whether the facility is providing safe and appropriate care and services to its residents. The emphasis throughout the inspection should be on observing residents as they go about daily activities, noting resident and staff interaction and how well the facility protects the rights of individuals, and assessing staff knowledge and attention to resident care needs.

This section is borrowed substantially from Minnesota Department of Health's, "10 Commitments for MDH Nurses Who Survey Assisted Living Home Care Providers."

2 Inspector Professionalism

As they conduct their inspections, inspectors will:

- Treat everyone they meet with dignity and respect, using "people skills" to make others feel as comfortable as possible;
- Maintain an open dialogue with administrators and staff members, while gathering the information needed to complete a fair evaluation of the facility's performance;
- Enforce the regulations and their official interpretations as written;
- Look for true patterns of noncompliance and risk to consumers, without being prescriptive in their enforcement of the standards;
- Remain objective during their information gathering, recognizing that things are not always as they appear at first glance;
- Protect confidential information gathered prior to and during the inspection, sharing it only with those who have the authority or permission to receive it; and
- Be aware of their own reactions to interpersonal conflict and strive to keep the inspection process on a professional footing.

3 Investigative Techniques

The focus of the inspection process should be to assess the actual delivery of care and services to residents. Though the inspector must evaluate provider compliance with standards about documentation, his or her foremost concern should be with the well-being of the residents. In order to do this adequately, the inspector must employ key investigative techniques for every inspection. To inspect means to check or test an individual or entity against established standards. Investigation, however, means to observe or

study by close examination and systematic inquiry for the purposes of making a determination (of compliance) based on an in-depth analysis of facts. Good investigative techniques should be a component of every inspection.

Facility reported incidents, unless investigated at the time of receipt because of allegations of abuse, neglect, or exploitation, should be considered for investigation during the course of a protocol inspection. Such reports should be gathered and reviewed prior to the inspection to identify patterns and potential areas to investigate.

3.1 Planning and Flexibility

Planning is essential in order to conduct a successful inspection. It assists in determining the pervasiveness and validity of violations and will aid your decision-making process. It should include both pre-planning before the start of the inspection and planning as you go since circumstances are unpredictable. As an example of pre-planning, a facility reported incident, unless investigated at the time of receipt because of allegations of abuse, neglect, or exploitation, should be considered for investigation during the course of a protocol inspection. Such reports should be gathered and reviewed prior to the inspection to identify patterns and potential areas to investigate. You should also consider any noncompliance from the previous inspection. Based on all of this information, think carefully about who needs to be interviewed, what records and documents you need to review, and any other evidence you might need to gather during the inspection.

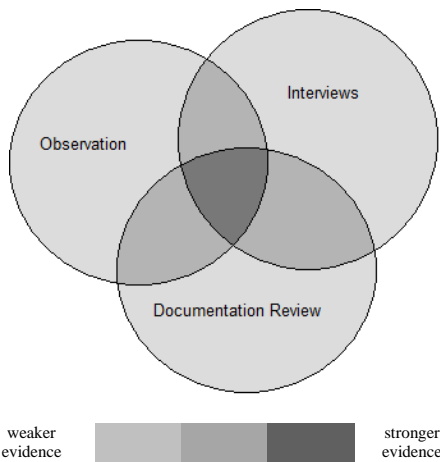
Though pre-planning and preparation are essential to the inspection process, flexibility during the inspection itself is equally important. Although you may have pre-conceived ideas and a pre-planned strategy for performing any given inspection, you must be able to adapt as situations change and evidence emerges. If you are presented with unanticipated issues, you must do any necessary investigation and follow-up to ensure all potential areas of noncompliance have been addressed.

3.2 Team Approach

A team may be used to perform inspections at any time. A team not only affords more opportunities for observations and interviews, but also provides on-site opportunities for discussion of issues, compliance determinations, and risk assessment. For example, a facility with a larger capacity may be an ideal scenario for a team inspection. Complicated complaint allegations may best be inspected by a team as well.

If a team approach is utilized, a team coordinator (normally the assigned inspector) should formulate a plan with assignments for interviews, observation of medication pass, documentation review, and the other tasks prior to entering the facility to avoid confusion and duplication of effort. It is also important to remember that the team members need to share their concerns and to continually communicate with one another throughout the inspection. For example, the team should regroup after completing initial observations, in order to determine which individuals to interview and whose records to review within the sample. (See Sample Selection Table in section 5.4.) The team approach offers many advantages and should be utilized whenever possible.





3.3 Evidence Verification

Inspectors must be thorough to ensure that compliance (or noncompliance) is accurately determined. It is important to verify information and to avoid making assumptions about what “appears” to be. For this reason, you should not share information with residents, family members, or facility staff and administration until you have made necessary observations and gathered your evidence. While you do not want to jeopardize collecting important evidence by discussing your concerns with providers prematurely, it is also essential that you inform them of potential violations at some point prior to the exit conference. This affords the provider the opportunity to produce information (including documents) that shows a citation is not warranted and helps inspectors avoid making conclusions without having all the facts.

There may be a very reasonable explanation for what may appear to be a violation during an initial encounter.

Example: A resident assessed as needing assistance with household chores is observed with an unmade bed at 4:00 p.m. This might appear to be a violation of the implementation of the ISP, but when asked, the resident explains she wasn’t feeling well, asked staff to let her sleep and chose to stay in bed for most of the day. That constitutes self-determination and not a violation.

Evidence is always strengthened when it is verified from a variety of sources. One observation or one document may be sufficient to support a violation, but serial observations of noncompliance made over an extended period of time are stronger than a single one. Along the same lines, an observation that is corroborated with an interview is strengthened by that interview. An observation, an interview, and a document combined present stronger evidence than a single observation, a single interview, or a single document. If you observe a situation that you believe to be non-compliant, do the necessary follow-through to actually make that determination. Document your discussions with residents and the provider. Include the name of the individuals with whom you spoke and the date, time, and details of the information shared. Retain your notes in the permanent record and include the details in any description of the violation. (See section 8.)



4 Tour

The initial tour is a unique opportunity to begin critical observations about a facility. Through careful observation (you should pay close attention to what you see, hear, smell, and touch) and the information offered by residents and staff, the inspector is able to form initial impressions about the facility and identify potential areas of noncompliance. This information helps the inspector(s) devise a strategy for implementing the remaining tasks of the inspection.

The tour actually begins with the first visual sighting of the facility. As the inspector, you should note any concerns with the exterior appearance and maintenance of the building and any potential safety issues. You should also note whether any residents are outside the building and in what type of activity they may be engaged. Once inside the building and after identifying and introducing yourself, you

should begin a *formal* tour with a focus on the population in care. If you delay this key task (even during complaint investigations), you risk losing valuable information and insight into what life is really like at the facility on a daily basis. **(Reminder: It is Division policy that all inspections be unannounced. [See SOP-301: Conducting an Inspection.]**)

While walking through the facility, you should introduce yourself to those in care and note any residents who may be candidates for interviews and whose file you may want to review. It is not advised to rely solely on staff suggestions about this, and generally your brief interactions with residents during the tour should give you sufficient information to make the selections. Also, you should note any family members present in the facility who could potentially be interviewed.

All potentially significant observations from the tour (as well as throughout the inspection) should be recorded legibly with the date and time and in sufficient detail to adequately and objectively describe them at any later point. Inspectors have the option of using the *Facility Review Form for Resident Centered Care* ([Appendix D](#)) for this purpose. The health, safety, and general welfare of the residents should be your primary concern. While the physical environment must be noted and addressed, this is largely to be assessed in terms of its impact on the residents. Focus on staff interactions with residents, tone of voice, expression, and so on. Pay particular attention to any resident with special needs or residents who fall outside of the “norm” as they should be considered for inclusion in the sample selection. Also, you should count staff on duty and note their positions, number of clients in care, and whether the personnel you observe on duty correspond accurately to the required postings. (NOTE: *What Your Inspector Needs from You Today* [[Appendix B](#)] is an excellent tool for obtaining much of this information.)

At the end of the tour, consider all of your observations and interactions with residents and staff, as well as the information you had gathered during your pre-planning efforts. Using the guidelines for sample selection in section 5.4, you can then begin to formulate your resident sample for the remaining tasks of the inspection. Remember to ensure that your sample is sufficient to determine if a potential violation is isolated in nature, affects a limited number of residents, or is potentially systemic.



5 Interviews

It has been stated already that the most important element of an inspection is the inspector’s assessment of resident care at the facility. Though the inspector can gather some information about resident care through observation and documentation review, interviews are essential for an accurate assessment. In fact, because they provide the most direct contact with those to whom the facility is providing care and services, inspectors should think of interviews as the component that drives the inspection.

Inspectors conduct the following during an inspection on an assisted living facility (see [Appendix E](#)):

- Resident interviews;
- Group interviews (optional);
- Family member/collateral interviews (in person or over the telephone); and
- Staff interviews (informally during the tour and other interviews as indicated).

5.1 Care and Program Assessment

The interview process is crucial to the inspector's ability to make an assessment of the provider's compliance with standards related to the following areas: rooms, environment, privacy, food, activities, staff, decisions, medical services, rules, personal property, rights, dignity, abuse and neglect, costs, building, transportation, and special care provisions. Inspectors can probe as well into other areas if, during the course of the interview(s), statements by the interviewee(s) indicate possible noncompliance with standards outside of those covered through typical interview questions.



5.2 Interview Guidelines

Inspectors should follow these procedures as they conduct interviews during the course of an inspection:

- The inspector will conduct interviews in person with individuals and (optionally) with groups, though interviews with family members or guardians may be conducted over the telephone. Other involved parties, such as caseworkers for example, may be interviewed if family members are unavailable;
- The inspector will introduce himself/herself, identify the purpose of the inspection, and ask permission of the person whom he/she intends to interview, as interviews are always voluntary;
- The inspector will conduct interviews in a manner that allows the greatest degree of privacy and confidentiality to interviewees;
- The inspector will develop a rapport with the person being interviewed, explain the purpose of the interview, focus interview questions on the care and services that the facility/program provides to residents/participants, and thank the interviewee at the conclusion of the interview;
- The inspector will document the date, time, and place of the interview(s), the name (and title) of the interviewee(s), and the information gathered during the interview(s), including quotations from the interviewee(s) as much as possible;
- The inspector will discontinue an interview if the interviewee seems uncomfortable or agitated, expresses a desire to stop the interview, or would be placed in an unsafe position at the facility/program if the interview were to continue;
- The inspector will not identify to the provider the names of persons interviewed without their permission; and
- The inspector will report immediately to adult protective services (APS) any allegations of abuse, neglect, or exploitation disclosed during the interviews.



5.3 Selecting Residents for Interviews

Once the inspector(s) has finished the tour, he or she should note any initial observations or concerns (or discuss them with other inspectors if using a team approach [see 3.2 above]) and begin the sample selection process. To meet the minimum requirements for interviews and to complete inspection tasks, it is necessary to integrate residents for individual, group (optional), & family/collateral interviews within the sample. It is not necessary for the inspector (or team) to do extra work unless a potential issue is identified that cannot be determined or resolved without expanding the sample.

Example: You identify Resident #1 as having more involved care needs, some mild cognitive impairment, and a staff member mentioned during the Tour that the resident’s daughter visits almost daily. This resident could satisfy the requirement for a record review and a family interview. You also observed Resident #2 with improperly stored medication in her room. She is alert and oriented and appropriate for an interview. She could be selected for the sample for follow-up with the medication issue, a record review, and an interview.

If the inspector(s) finds widespread noncompliance with potential risk to residents, then **the sample should be expanded** to ensure that the pervasiveness is adequately assessed. Any resident interviewed – with the exception of the optional group interview – should be added to the sample and formally recorded on the supplemental page using an identifier to protect confidentiality.

SPECIAL CARE UNITS

In the case of facilities with special care units composed of residents with dementia, inspectors need to take special measures to ensure they obtain accurate information about resident care and services. Inspectors should observe the following guidelines:

- Spend as much on site time as possible observing staff/resident interactions, activities, assistance with meals, behavioral interventions, etc. The assessment of the facility’s ability to meet the unique needs of these residents is facilitated by making serial, extended observations of care on the unit.
- Obtain at least one of the family/collateral interviews required in the sample selection table from the special care unit population. **(If the facility is a free-standing special care facility for residents with dementia and has no other units, then the individual interview requirements in the Sample Selection Table [section 5.4] can be waived.)**
- Carefully review the ISP, UAI and other assessment data for accuracy and observe staff for implementation of appropriate interventions.
- Ask yourself the following questions: Are staff members meeting resident care needs? Do residents appear neat, clean, adequately groomed, and odor free? Are facility activities appropriate? Are residents engaged in activities (both formal and informal) adequately to prevent maladaptive behaviors? Does the facility staff recognize and respond appropriately to negative behaviors with timely interventions before they escalate? Are the safety needs of the residents being met?
- Interview staff informally to determine their understanding of the needs of the residents selected for the sample and the adequacy of the provider’s training to meet those needs. Review staff records if concerns are identified.

All other required inspection tasks should be completed for these providers as you would for others.

5.4 Sample Selection Table

Minimum sample selection for interviews, record reviews, and the medication pass during a protocol inspections at an assisted living facility are as follows:

Resident Census*	# of Interviews (individual/ family)	# of Record Reviews (resident/staff for protocol inspections)	Medication Pass Sample (Meet requirement by # of opportunities for error or number of residents observed receiving medications. <i>[NOTE: Inspector must observe a minimum of 8 opportunities for error.]</i>)
1 – 9	1/1	4/3	10 or 2 residents
10 – 34	2/1	6/3	15 or 3 residents
35 – 65	3/2	8/4	20 or 4 residents
66 & above	4/2	10/5	25 or 5 residents

*Note: The “census” includes all residents who are currently residing in the facility at the time of the entrance. Do not include anticipated admissions.



6 Medication Pass Observation

Proper medication administration is essential to the health and well-being of residents in any assisted living facility. This is why it is so important that inspectors are diligent in their enforcement of standards relating to the handling, storage, and delivery of medicines.

The inspector should use standard techniques for observing a medication pass on all routine inspections and complaint investigations that include allegations related to medications as indicated. There are three basic components:

- Observation of Medication Pass;
- Review of Records for Medication Errors; and
- Inspection of Medication Storage.

The focus of the medication pass observation and review of records should be on the “five rights” of medication administration as follows:

THE FIVE RIGHTS
1. The right resident;
2. The right medication;
3. The right time;
4. The right dose; and
5. The right route.

A determination that an error has been made should be based on these “five rights.”

6.1 Observation of Medication Pass

Inspections are intrusive by nature and may increase the anxiety level of provider staff. This is particularly the case in relation to medication administration observation activities. Therefore, every effort should be made to be as respectful to all staff and to cause as little disruption as possible in the routines of staff observed during the medication pass.

Begin the medication pass observation by introducing yourself to the staff person and briefly explaining the process. Explain that you would like the staff to proceed as they would normally, but that you must observe them throughout and that you will be recording observations – this is the “normal” procedure. Make sure they understand you must be able to record the details of each medication label before the medication is poured regardless of the type of distribution system used (bubble pack, etc.), since you may not be able to simultaneously read the Medication Administration Record (MAR). Also, inform staff that you will accompany them into the resident’s room (after requesting permission from the resident) as you must watch the medications actually being given. Once you have completed that portion of the protocol, you will then compare the physician orders to the MAR and will discuss any discrepancy with the appropriate staff. Encourage the staff to ask questions and then begin your formal observations.



Use the *Medication Pass Observation Worksheet* ([Appendix F](#)) to record your observations. In addition to recording the resident’s name, room number, and the information from the medication label, you should focus on the primary steps of the actual medication administration as follows:

1. Staff sanitizes hands;
2. Staff has MAR open and in use – each medication is checked by label and against the MAR for accuracy;
3. Each medication is placed accurately into a medication cup (or poured if liquid, etc.);
4. The cart (if used) or med room is secured before entering the resident’s room;
5. The resident is accurately identified;
6. The resident actually receives the medication; and
7. The medication is recorded as given.

Once the observation has been completed, the physician’s orders and the MAR must be reconciled to determine if the five rights have been met (refer to section 6.2).

Inspectors are expected to observe the minimum number of opportunities for error **or** number of residents based on the table below and the census at the facility:

SAMPLE SELECTION TABLE

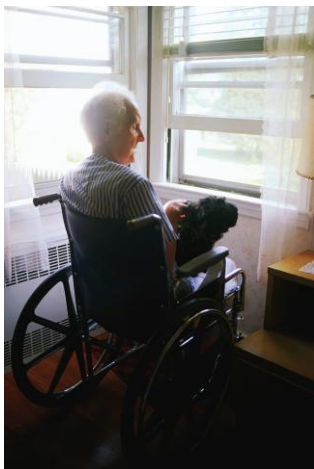
Resident Census	# of Interviews (individual/ family)	# of Record Reviews (resident/staff for protocol inspections)	Medication Pass Sample (Meet requirement by # of opportunities for error or number of residents observed receiving medications. <i>[NOTE: Inspector must observe a minimum of 8 opportunities for error.]</i>)
1 – 9	1/1	4/3	10 <i>or</i> 2 residents
10 – 34	2/1	6/3	15 <i>or</i> 3 residents
35 – 65	3/2	8/4	20 <i>or</i> 4 residents
66 & above	4/2	10/5	25 <i>or</i> 5 residents

For example, in a facility with a resident census of 45, Resident # 1 has five medications Resident # 2 has three medications ordered. That would equal 8 opportunities for error, so 12 additional observations would be required. **Or**, the medication pass observation requirement may be met by observing any number of medications for 4 individual residents. (NOTE: The minimum number of opportunities for error to observe is eight, regardless of census.)

If possible, try to observe different staff on different shifts at varying times of the day. If the tech has already begun pouring medication for a resident as you approach, wait until he or she has finished and is ready to start pouring medications for the next resident, otherwise you will be unable to determine if all ordered medications are given for a particular resident at the appropriate time. Also note if medications are given before or after meals, with liquids, crushed or in food as errors in these areas may be significant.

Ensure that you are able to see the label on the medication regardless of the type of distribution system in use (bubble packs, individual bottles, inhalers, etc.). Record the name of the drug, amount, strength, number of pills dispensed, etc. If liquid medication is being given, you must determine the amount by observing the liquid at eye-level. If a syringe is used, you must visualize and record the volume on your worksheet (before it is given). If at all possible, observe medications administered to diabetics as they tend to be problematic. (NOTE: Further resource materials on medication administration and medication pass observation can be found on DOLP's shared [L:] drive.)

Do not comment on the medication pass except to clarify details **unless** you believe an error is going to be made, (such as a wrong dose, wrong resident, wrong route, etc.). If you do believe an error is about to occur, you must intervene and address the issue by questioning the staff or advising him or her of the error. You may wait until you are sure the staff is prepared to actually give the drug before you intervene.



6.2 Review of Records for Medication Errors

After you have completed the required observations, you must reconcile the medications given with those ordered. Check your observations with the physician orders first, and then check the MAR. If you just check the MAR, you are assuming the MAR is correct which may or may not be true. You must also check the record for verbal and telephone orders as the most recent order supersedes previous orders.

Count any deviation from the medication orders as an error. For example, Reglan 10 milligrams is ordered to be given ½ hour a.c. (before meals), but you observe it given after meals. That would be an error and should be cited. Tylenol 325 milligrams (2) is ordered to be given at 9 am, but the staff administers one pill. That would be a wrong dose error and should be cited. Please use judgment when determining medication errors. For example, the standard practice allows medications to be considered “timely” if given an hour before or an hour after the time actually specified in the order. However, you observe a medication given one hour and five minutes after the time specified. Unless several residents received medications after that time, it might not be appropriate to cite this as an error.



After you have completed the medication pass and have reconciled the orders with your observations, discuss any discrepancies with the staff you observed. Do not wait to do this, as your findings are strengthened by immediately interviewing the staff. There may be a simple explanation for what you think is a violation, or the person may make statements that verify and corroborate your observations. Record staff responses carefully and include the date and time. Then share any concerns with the administrative staff or let them know no errors were identified. Also, don't forget the residents in all of this, since they may have pertinent comments or observations as well.

Include the staff you observed during the medication pass in your selection of staff records to be reviewed, as indicated in section seven. Verify documentation of the appropriate training/licensure and any annual or refresher training required by the regulations for that position. If you observe violations, include the particular resident records in your sample (add as an expanded sample and do a focused record review if necessary). You need only review the portions of the record relevant to the violation, (but at a minimum, record the resident name, date of birth, diagnoses and original doctor's order).

6.3 Inspection of Medication Storage

The medication room and storage area as well as the type of medication cart (or furniture) used may vary greatly from facility to facility. Refer to the regulatory requirement for parameters of acceptable storage systems. As in the medication observation in general, make every attempt to cause as little disruption to the staff routines as possible. *Never check a medication cart or storage area without a qualified staff person present.*

Begin by noting whether the room/cart is locked and who might have access to it. Scan the exterior of the cart (or interior of the storage area) for general cleanliness and order. It is not necessary to check every medication drawer for every resident. Simply perform a random check of several individual storage areas.

7 Record Reviews

The sample selection table outlines the **minimum** requirements for resident and staff record reviews:

SAMPLE SELECTION TABLE



Resident Census	# of Interviews (individual/ family)	# of Record Reviews (resident/staff for protocol inspections) <i>Also review criminal background checks for all new staff (since the last inspection)</i>	Medication Pass Sample <i>(Meet requirement by # of opportunities for error or number of residents observed receiving medications. [NOTE: Inspector must observe a minimum of 8 opportunities for error.]</i>
1 – 9	1/1	4/3	10 or 2 residents
10 – 34	2/1	6/3	15 or 3 residents
35 – 65	3/2	8/4	20 or 4 residents
66 & above	4/2	10/5	25 or 5 residents

To the extent possible, based on the number of records reviewed, the following areas should be present in the sample: 1) X [number of] records of new residents, 2) X records from special populations [dementia, restrained, or aggressive persons], 3) X records from closed resident files, and 4) X records from auxiliary grant recipients [if applicable; use form in [Appendix G](#)]. It is essential that the inspector select records to review based on information gathered during the inspection. The inspector should not ask the provider to choose which record(s) to include in the sample.

Though these minimum requirements must be met for all protocol inspections, the inspector must ensure as well that the sample size for record reviews (as with interviews) is sufficient to determine the pervasiveness of any given deficient practice. This is critical in determining how many residents are affected or potentially affected by the provider's noncompliance. If the inspector identifies an issue with one resident, he or she must also determine if it is a problem for others for the simple reason that as the pervasiveness of a problem increases, so does the risk of harm to any persons in care.

There is a balance that inspectors must find, however, between being thorough and using their and the provider's time efficiently. Inspectors must collect sufficient evidence to make a compliance determination, but must also know when they have been reasonably thorough and should stop. Inspectors may use the (optional) *Record Review Form* ([Appendix H](#)) to help them ensure they have looked at all core standards related primarily to documentation requirements.

REVIEW OF STAFF RECORDS

In addition to resident record review at *each* protocol inspection, the inspector must review key items from a specified number of staff records, as follows (also in [Appendix I](#)):

- Review one record from each:
 - 1) Any newly hired current staff member
 - 2) The med tech observed performing the medication pass
 - 3) Any current staff member
- Review the following items in each of the staff records reviewed:
 - 1) Staff qualifications (ex. the license for a nurse or documentation of qualifications for direct care staff)
 - 2) TB screening
 - 3) Criminal background checks
 - 4) First aid and CPR certification
 - 5) Staff training
- Review the criminal history background checks for all new staff hired since the last inspection.

Though this represents the minimum requirement for this periodic review, the inspector can expand the number of records and the number of items to examine if he or she has been alerted to potential problems through observation and interviews (as described in sections 4 and 5).

Before starting a review of records it is important to determine exactly which items need to be verified and/or investigated in the sample files, based on potential problem areas or noncompliance identified through observations and interviews.

It is important that inspectors work strategically and efficiently in the time spent on-site with documentation review. If one is not careful, too much of the limited amount of time at the facility can be spent on this task with little result, instead of focusing primarily on interacting with and observing those who live in the facility. Before starting a review of records it is important to determine exactly which items need to be verified and/or investigated in the sample files, based on potential problem areas or noncompliance identified through observations and interviews.

8 Citation of Violations

Inherent in the philosophy of the regulatory environment is the concept of culpability. The inspector must always ask, "Did the provider have knowledge of this, or should they have known?" Observations that are incidental do not necessarily constitute violations.

Example: You observe a resident with oatmeal dribbled down the front of his shirt at 8:30 am, just after the breakfast meal. The ISP indicates the resident requires assistance with eating, dressing, and personal care. There are no direct care staff in the area at the moment. Is this a violation? Have the staff had a reasonable amount of time to assist the resident? If you observe three staff pass by the same resident and do nothing to assist, and you again observe him in the same state at 9:30 am, is this a violation? Yes, you have answered the issue of culpability—three staff passed by the resident without offering assistance and you have serial observations of the resident in need of care.

One way to guide your decision making is to structure your "description of violation" in two parts:

- Description of noncompliance and

- Description of the evidence.

By using this method, you may find once you begin to draft your portion of the violation notice that you do not have strong enough evidence to support a citation. You will also discover that by structuring your description of violation in this way, your citation will be much more defensible. (NOTE: What follows is the format prescribed in *SOP-304: Violation Notices and Inspection Summaries* for writing the description of violation.)



8.1 Description of Noncompliance

The description of noncompliance should include the following elements:

- A statement about the specific action(s), error(s), and/or lack of action;
- A brief sketch of any negative outcome(s)/consequences(s) resulting from the noncompliance;
- A numerical quantification of the extent of the noncompliance and identifiers for individuals listed in the extent of noncompliance statement; and

Example: “Four out of 11 residents (#s 1, 3, 7, 8)...” **Note that in order to protect the confidentiality of residents, for resident interviews one only need mention the following, “Four out of 11 residents stated” (without the identifiers).**

- A reference to the source of the evidence (observation, interview, and/or review of records).

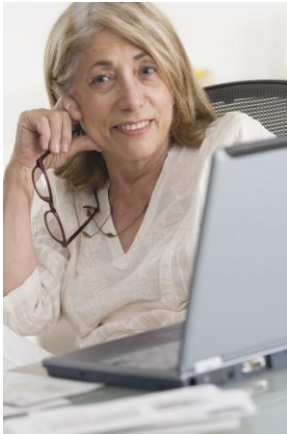
8.2 Description of the Evidence

The description of the evidence should include the following elements:

- Specific facts that demonstrate each issue mentioned in the description of noncompliance;
- Descriptions of actions, situations, sources of information, and any negative outcomes/consequences relative to the noncompliance; and

NOTE: Facts described should address the who, what, when, where, and how of the noncompliance and should be presented in a chronological and logical order.

- An assessment of the extent, frequency, and severity of the action(s) or non-action(s).



8.3 Example: Description of Noncompliance and Description of Evidence

STANDARD NUMBER:	DESCRIPTION OF VIOLATION:
22VAC40-72-840-G	<p>Based on observations and interviews, the facility failed to maintain water temperature within the acceptable range in 2 out of 4 sampled resident bathrooms and one common restroom.</p> <p><i>(DESCRIPTION OF NONCOMPLIANCE)</i></p> <p>Evidence: <i>(DESCRIPTION OF THE EVIDENCE)</i></p> <ol style="list-style-type: none"> 1. On 9/24/04 at 2:25pm the inspector interviewed a resident who said, "...the water can get awful hot," referring to the water that comes out of the shower in the resident's bathroom. The inspector tested the water in the resident's bathroom and found the hot water to be 140° F. 2. On the same day at 2:40pm the inspector spoke to another resident in the same wing of the facility who stated, "The water is too hot in my sink. I've burned myself several times when I've turned it on to wash my hands." The inspector tested the water in the resident's sink and found the hot water to be 138° F. 3. Later in the day, at 3:40, while inspecting the men's common bathroom next to the dining area, the inspector tested the water temperature with a thermometer and the hot water reading was 144° F.

9 Acknowledgements

The Division of Licensing Programs would like to acknowledge that some of the materials in this document were inspired by and adapted from the following sources:

State Operations Manual, Appendix P: Survey Protocol for Long Term Care Facilities (Revision 22: December 2006) and Principles of Documentation for the Statement of Deficiencies (2000), Centers for Medicare and Medicaid Services, United States Department of Health and Human Services

A Guide to the Survey Process for Assisted Living Home Care Providers (November 2004) and ALHCP 2620 Informational Memorandum: Licensing Survey Form (July 2006), Minnesota Department of Health

Putting People Who Use Care Services at the Center of Our Work, a presentation by Alan Jefferson (Director, Northwest Region, Commission for Social Care Inspection, United Kingdom) at the 16th Annual Licensing Seminar of the National Association for Regulatory Administration (Richmond, Virginia: October 8-10, 2007)

Appendix A: Entrance Conference Brochure

(For a new facility and/or administrator)

The inspection is at the center of the work of the Division of Licensing Programs. Its purpose is to evaluate and monitor the compliance at this facility with applicable standards for licensure. It also gives you the chance to demonstrate the systems in place to provide care and services to your residents. In order to achieve these goals effectively, the inspector will complete the six components of an inspection while using thorough investigative techniques.

The Division of Licensing Programs considers the benchmark of compliance to be your ability to deliver essential care and services to residents. Therefore, the inspector will prioritize the gathering of information from residents themselves on how well you have done in the areas that matter most to them. Additionally, the inspector will use observation techniques and documentation review to assess your compliance in key areas and to evaluate your overall performance.

The inspection is at the center of the work of the Division of Licensing Programs. Its purpose is to evaluate and monitor the compliance at this facility with applicable standards for licensure. It also gives you the chance to demonstrate the systems in place to provide care and services to your residents. In order to achieve these goals effectively, the inspector will complete the six components of an inspection while using thorough investigative techniques.

INSPECTOR PROFESSIONALISM

WHAT YOU CAN EXPECT FROM YOUR INSPECTOR

As they conduct their inspection, inspectors:

- Test everyone they meet with dignity and respect, using "people skills" to make others feel as comfortable as possible;
- Maintain an open dialogue with directors and staff members, while gathering the information needed to complete a fair evaluation of the facility's performance;
- Enforce the regulations and their official interpretations as written;
- Look for true patterns of noncompliance and ask to comment, without being prescriptive in their enforcement of the standards;
- Remain objective during their information gathering, recognizing that things are not always as they appear at first glance;
- Protect confidential information gathered prior to and during the inspection, sharing it only with those who have the authority or permission to receive it; and
- Are aware of their own reactions to interpersonal conflict and strive to keep the inspection process on a professional footing.



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Division of Licensing Programs
801 East Main Street / Richmond, VA 23225
www.dss.virginia.gov

Inspector: _____
Phone #: _____

Virginia Department
of Social Services
**Division of Licensing
Programs**

Provider
Guide to the
Inspection
Process

THE SIX COMPONENTS

There are six basic components of an inspection:

- 1. Entrance Conference** – Inspectors introduce themselves, outline the basic components of the inspection process, and ask for items they will need to conduct the inspection.
- 2. Tour** – Inspectors walk through the building(s) directly after the entrance conference and as soon as possible after arrival in order to talk to staff and residents, observe interpersonal interactions and activities, check on food preparation and delivery of meals, and examine the physical plant.
- 3. Interviews** – Inspectors talk to staff, residents, participants, and/or their guardians to gather information about the facility's compliance with standards, particularly those that relate to resident care and provided services.
- 4. Observations** – Inspectors observe – from the moment they drive up to the building to the conclusion of the inspection – what is happening in the facility in order to assess compliance with standards. Inspectors pay special attention to the interaction between staff and residents, the execution of the facility's internal policies and procedures, the quality and participation in learning and recreational activities, and the degree of staff and precision in medication storage and administration.
- 5. Documentation Review** – Inspectors examine policies and procedures, posted signs and notices, and a sampling of personnel and resident/participant records.
- 6. Exit Meeting** – Inspector(s) review the results of the inspection with the provider, listen to and discuss with the provider any disputed findings and/or comments about the inspection process, provide consultation, and request from the provider a description of the actions that will be taken to correct any violations and ensure future compliance. The inspector will often be able to provide the completed violation notice for signature by the provider at the exit meeting, but if not will at least discuss preliminary findings with the provider.

SAMPLE * SCHEDULE FOR REGULAR INSPECTORS AT ASSISTED LIVING FACILITIES

Day One	Day Two
Morning	Morning
Entrance Conference	Medication Pass
Tour <i>(Intr. some 1st/2nd/3rd interviews)</i>	Record Review
Observe lunch	Follow-up from Day One
Afternoon	Afternoon
Interviews <i>(When 1st/2nd/3rd interviews from AM, conduct individual & group interviews)</i>	Final Record Review
	Exit Meeting

**Though the entrance conference, tour and exit meeting would occur at the beginning and end of the inspection as described above, the other items need not occur in the same order for each inspection and some activities may take longer than the sample schedule indicates.*

WHAT YOUR INSPECTOR NEEDS FROM YOU TODAY

Your inspector will ask you to collect some information about this facility, which will be necessary for the completion of the inspection. Please supply your inspector with this information as soon as possible. Items include:

- Today's census _____
- Names (and room numbers of residents) of _____ (date)
- New admissions since the last inspection on _____ (date)
- Closed files since the last inspection (discharge, death)
- Residents with whom you have used (or could use) restraints
 - ❖ Residents with special needs:
 - wound care
 - special care unit
 - non-ambulatory
 - aggressive behaviors
 - serious cognitive impairment
 - HIV, AID, AIG,
 - on hospice,
 - using oxygen and
 - receiving home health care
- Staff list and include (highlight names of new staff [since last inspection]) _____
- Any changes to the medication management plan?
- Date of health care oversight review(s) since the last inspection _____
- Date of last fire inspection _____
- Date of last health inspection _____
- Date of last practice plan for fire emergency _____
- Date of fire 3 file & emergency evacuation drills _____
- Date of last quarterly review of emergency preparedness & response plan _____
- Date of last on-site quarterly oversight by a director or manager _____

Appendix B: Request for Facility Information at Entrance Conference



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

Division of Licensing Programs

WHAT YOUR INSPECTOR NEEDS FROM YOU TODAY

Fill in blank spaces and use the back of this page and/or attach additional pages for lists:

- Today's census _____
- Names (and room numbers of residents) of the following:
 - ❖ New admissions since the last inspection on _____ (date)
 - ❖ Closed files since the last inspection (discharges, deaths)
 - ❖ Residents with whom you have used (or could use) restraints
 - ❖ Residents with special needs:
 - wound care;
 - special care unit;
 - non-ambulatory;
 - aggressive behaviors;
 - serious cognitive impairment;
 - MH/MR/AG;
 - on hospice;
 - using oxygen; and
 - receiving home health care.
- Staff list and schedule (highlight names of new staff [since last inspection])
- Any changes to the medication management plan? If so provide.
- Date of health care oversight reviews (s) since the last inspection _____
- Date of last fire inspection _____
- Date of last health inspection _____
- Date of last practice of plan for resident emergencies _____
- Dates of past 3 fire & emergency evacuation drills _____, _____, _____
- Date of last quarterly review of emergency preparedness & response plan _____
- Date of last on-site quarterly oversight by a dietician or nutritionist _____

Facility: _____

Date: _____

Appendix C: Inspection Notice

NOTE: *Inspector should hand this to the administrator at the entrance conference and ask that it be posted at the entrance of the facility for everyone to see.*

INSPECTION NOTICE

***AN UNANNOUNCED
ASSISTED LIVING FACILITY
INSPECTION IS BEING CONDUCTED
BY THE INSPECTOR FROM THE
VIRGINIA DEPARTMENT OF
SOCIAL SERVICES***

***THE INSPECTOR(S) WILL BE WEARING A VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
IDENTIFICATION BADGE***

***ANY RESIDENT MAY TALK PRIVATELY
WITH AN INSPECTOR WHO IS HERE***

***AFTER THE INSPECTION, YOU MAY
CONTACT OUR OFFICE AT***

() -

(Add licensing office phone number. 📞)

Appendix D: Facility Review Form for Resident Centered Care

Facility Review Form for Resident Centered Care	
Facility Name:	Inspection Date:
Inspector Name:	
HOW TO USE THIS FORM	
This is an optional form, which can be used to assist the inspector in taking notes (in the margins or on the back) and keeping track of key standards for observation and review during the inspection. If notations are made on this form it should be retained in the facility record, along with any other notes, required forms, or other applicable materials related to the inspection.	
KEY AREAS OF OBSERVATION AND DOCUMENTATION REVIEW	
Observation:	
<ul style="list-style-type: none"> <input type="checkbox"/> An adequate number of direct care staff members are observed on duty and to be treating residents with dignity and respect, handling with professionalism and competence any conflict or specialized need. (22 VAC 40-72-320 [1000, & 1110]) <input type="checkbox"/> Meals are served in the dining area, residents have at least 30 minutes to complete their meals, and staff members are present to assist residents as needed. Meals served outside of the dining area reflect appropriate resident circumstances. (22 VAC 40-72-580) <input type="checkbox"/> Resident rooms appear clean and comfortably furnished and decorated with personal items from the resident and/or all required items. (22 VAC 40-72-730 [850]) <input type="checkbox"/> Shared spaces at the facility are clean, comfortably and adequately furnished, and equipped with all required supplies. (22 VAC 40-72-740 [760, 760, and 850]) <input type="checkbox"/> Buildings and grounds are adequately lighted, heated & cooled, ventilated, free of hazards, safe, in good repair, clean, provided with adequate handrails and non-slip surfaces, etc. (22 VAC 40-72-840 [850, 860, 870, 1050, 1130, and 1160]) <input type="checkbox"/> Sleeping areas are adequately sized and beds are positioned appropriately. (22 VAC 40-72-880) <input type="checkbox"/> Adequate bathroom facilities are provided in resident rooms and in public spaces and are adequately stocked with necessary supplies. (22 VAC 40-72-890 [8,900]) <input type="checkbox"/> Facility staff members provide – according to what is printed on the calendar and what the inspector finds through interview and observation – regular, scheduled, varied, and appropriate activities and recreation and it encourages resident participation. Observed activities seem to support the physical, social, mental, etc. needs of residents. (22 VAC 40-72-520 [8, 1100]) 	
Documentation Review:	
<p><i>NOTE: The inspector need only look, generally, at these areas for the residents included in the sample and need only go back from the date of the current to that of the previous inspection (unless otherwise noted).</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> The provider ensured that the resident obtained a physical exam, including screening for tuberculosis (with follow-up evaluations as necessary), within 30 days prior to the date of admission. (Check only for any new resident[s] in the sample. [22 VAC 40-72-350]) <input type="checkbox"/> The provider protected its residents by ensuring proper, timely mental health screening for any resident (or potential resident in the case of a new admission) whose behavior (or history) was indicative of mental illness, mental retardation, substance abuse, or behavioral disorders that could cause concern for that resident or any of the other residents. (22 VAC 40-72-360) The provider did the same for residents with a serious cognitive impairment. (22 VAC 40-72-1070, 1080, and 1090) <input type="checkbox"/> The provider maintains an updated uniform assessment instrument (UAI) for its residents and applicants for admission to the facility. (22 VAC 40-72-430) <input type="checkbox"/> The provider shall develop an individualized service plan (ISP) based on the needs assessed in the UAI and in conjunction with the wishes of the resident. Based on interviews and observations, it appears that the care and services provided to the resident at the facility are in line with those identified in the resident's ISP. (22 VAC 40-72-440) <input type="checkbox"/> The provider assumes responsibility for the health, safety, and well-being of its residents. The provider assures that their health care needs – including any restorative, habilitative, and rehabilitative services, along with health care dietary oversight – are met. The provider does this while protecting residents' independence, rights, and decision making authority related to their healthcare and quality of life. (22 VAC 40-72-450 [460, 470, 480, 500, 620, 680, and 690]) <input type="checkbox"/> Physician's orders match the medication administration record and the observed delivery of medication. (22 VAC 40-72-670) <input type="checkbox"/> The provider has used restraints only under certain conditions and with the proper notifications and documentation. (22 VAC 40-72-700) 	

Appendix E: Interview Form for Assisted Living Facility Inspections

ONE-PAGE VERSION:

Interview Form for Assisted Living Facility Inspections <small>(Retain this form in the facility record.)</small>	
Facility Name: Inspector Name: 	Inspection Date:
INDIVIDUAL INTERVIEW	<i>Person(s) interviewed:</i> _____
<p>RESIDENT ROOM (room, temperature, pet, call system, etc. [22 VAC 40-72-730, 840 {910}])</p> <p>FACILITY ((clean, shared spaces OK, bugs, mice, fire drills, etc. [22 VAC 40-72-540, 740, 840, 850])</p> <p>ACTIVITIES (adequate, participation, trips, etc. [22 VAC 40-72-520, 1000, 1100])</p> <p>FOOD (temperature, taste, quantity, seconds, snack, special diet, etc. [22 VAC 40-72-580 {620}, 750])</p> <p>STAFF (responsive, available, Are you safe?, etc. [22 VAC 40-72-50, 240, 320, 450, 700, 1060, 1110])</p> <p>RIGHTS AND DIGNITY (money management, decision making, freedom of choice, rules, resident rights, appropriate care, etc. [22 VAC 40-72-120 {150}, 340, 390, 450 {470}, 520, 530, 550])</p> <p>HEALTH CARE & MEDICATIONS (special needs met, choice of doctor, self-medicated, outside services, etc. [22 VAC 40-72-460 {480}, 500, 670, 690, 770])</p>	
FAMILY MEMBER/COLLATERAL INTERVIEW	<i>Person(s) interviewed:</i> _____ <i>Relationship to resident:</i> _____
<p>ADMISSION (initial impressions/changes, disclosure, visitation, etc. [22 VAC 40-72-40, 60, 520, 540])</p> <p>PERSONAL CARE AND SUPERVISION (personal needs, services, communication, notification of concerns, restraints, wandering – your family member or other residents, etc. [22 VAC 40-72-450, 700, 780, 790])</p> <p>FACILITY (room condition, cleanliness, supplies, mail, phone, etc. [22 VAC 40-72-740, 780, 790, 850 {880}])</p> <p>FOOD (adequate, preferences, special diet, notices, weight loss/gain, etc. [22 VAC 40-72-580, 590, 620, 750])</p>	

TWO-PAGE VERSION:

Interview Form for Assisted Living Facility Inspections

(Retain this form in the facility record.)

Facility Name: [REDACTED]
Inspector Name: [REDACTED]

Inspection Date: [REDACTED]

INDIVIDUAL INTERVIEW

Person(s) interviewed: _____

RESIDENT ROOM (room, temperature, pet, call system, etc. [22 VAC 40-72-730, 840 {-910}])

FACILITY ([clean, shared spaces OK, bugs, mice, fire drills, etc. [22 VAC 40-72-540, 740, 840, 850])

ACTIVITIES (adequate, participation, trips, etc. [22 VAC 40-72-520, 1000, 1100])

FOOD (temperature, taste, quantity, seconds, snack, special diet, etc. [22 VAC 40-72-680 {-620}, 750])

STAFF (responsive, available, Are you safe?, etc. [22 VAC 40-72-50, 240, 320, 450, 700, 1060, 1110])

RIGHTS AND DIGNITY (money management, decision making, freedom of choice, rules, resident rights, appropriate care, etc. [22 VAC 40-72-120 {-150}, 340, 390, 450 {-470}, 520, 530, 550])

HEALTH CARE & MEDICATIONS (special needs met, choice of doctor, self-medicated, outside services, etc. [22 VAC 40-72-460 {-480}, 500, 670, 690, 770])

Interview Form for Assisted Living Facility Inspections

(Retain this form in the facility record.)

Facility Name: [REDACTED]
Inspector Name: [REDACTED]

Inspection Date: [REDACTED]

FAMILY MEMBER/COLLATERAL INTERVIEW *Person(s) interviewed:* _____
Relationship to resident: _____

ADMISSION (initial impressions/changes, disclosure, visitation, etc. [22 VAC 40-72-40, 60, 520, 540])

PERSONAL CARE AND SUPERVISION (personal needs, services, communication, notification of concerns, restraints, wandering – your family member or other residents, etc. [22 VAC 40-72-450, 700, 780, 790])

FACILITY (room condition, cleanliness, supplies, mail, phone, etc. [22 VAC 40-72-740, 780, 790, 860 {-880}])

FOOD (adequate, preferences, special diet, notices, weight loss/gain, etc. [22 VAC 40-72-580, 590, 620, 750])

Appendix F: Medication Pass Observation Worksheet

Medication Pass Observation Worksheet

(Use multiple pages as necessary and retain in the facility record)
5 Rights = (1) Resident (2) Medication (3) Time (4) Dose (5) Route

Facility Name	Inspector Name	Medication Tech Name	Date & Time

Room #	Resident Name	Drug Name, Dose, & Form	Observation of Administration		MAR Matches		Medication Storage Clean & Organized, Stored, Locked, Employee has key
			<input type="checkbox"/> Vitals <input type="checkbox"/> Patch <input type="checkbox"/> Liq. <input type="checkbox"/> Spray/Drops <input type="checkbox"/> Inhaler/Neb <input type="checkbox"/> Bld Chks <input type="checkbox"/> Insulin <input type="checkbox"/> M & M <input type="checkbox"/> Hands <input type="checkbox"/> ID <input type="checkbox"/> Documentation		Meds	Phys Orders	

NOTE: The Inspector should be looking for evidence of non-compliance relating to any of the items in the following standards:
22 VAC 40-72-640, 22 VAC 40-72-650, and 22 VAC 40-72-670

Page ____ of ____

Appendix G: Auxiliary Grant Recipient Review Form

AUXILIARY GRANT RECIPIENT REVIEW FORM

(NOTE: Inspector *must* use this form during an inspection at a facility in which one or more auxiliary grant recipients reside and may use this form at a strictly private pay facility at which he or she suspects/discovers potential concerns with how resident funds are managed, recorded, and/or distributed.)

Standard	Resident Sample Number							
	1	2	3	4	5	6	7	8
Is resident AG (for Auxiliary Grant) or P (for Private Pay)?								
Monthly Statement								
140 – Monthly itemized statement is in Resident's Record.								
140 – Monthly itemized statement given to Resident or Legal Rep.								
550 C (63.2-1808 A.10) – Services/products billed are actually received by resident								
550 C (63.2 – 1808 A.3 and A. 10) -- Services/products were actually wanted by the resident per the <u>Resident Agreement</u> .								
50 A. -- Charges are allowable under AG Regulation.								
Resident Agreement								
390 A. 1. a. and b.-- Charges on the monthly statement are listed in the <u>Resident Agreement</u> .								
Safeguarding Funds (Only applies if resident delegates management of personal funds to the facility.)								
150 A. 1. – Documentation that resident delegated money management to facility is in record.								
150 A. 2. – Personal Needs Allowance held separately from facility's bank account.								
150 A. 4. Written accounting of money received and disbursed is maintained and available to resident or legal rep.								
150 A. 4. – Resident interview indicates personal funds are being received.								

Use the section below to record information gathered during the inspection (through interview, observation, and/or documentation review) pertinent to how resident funds are managed, recorded, and/or distributed. (NOTE: Some standards relate specifically to auxiliary grant recipients, while others apply to the management of funds for any resident, regardless of source.)

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Resident # ___ : _____

Facility: _____

Appendix I: Staff Record Review Form

REVIEW OF STAFF RECORDS*

Facility: _____

(NOTE: This is a focused review on [1] staff credentials, [2] TB screening, and [3] criminal background check.)

STAFF	290.C.5	290.C	290.C	290.C	290.C.8	290.D.1	290.C.9	250.C 290.C.11	300.C	300.B	550.F	180	260.A-B	660.1	1010.B	1120.A	1120.B		
			annual	signed		annual	orig	orig	CNA, LPN, HHA cert	all staff/Not RN/LPN	1 on duty at all times	annual	w/in 7 days	Res (8) Lic (12) Else (16)	refresh 3 years side/ann	w/in 4 mos/ cog imp	w/in 2 mos/ dementia	w/in 1 year/caring for	
	DOH	P. Data	Eval	Deec	2 Ref.	TB	CRC	SD	Qualified	First Aid	CPR	Res Right Rev	Orient	Training	Med Cert	4 hrs mixd	4 hrs SCU	6 hrs SCU	
██████	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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*Sample to include: 1) a newly hired staff member, 2) the observed med. tech, 3) any other staff member, and 4) review of criminal history background checks for all new staff hired since the last inspection. The inspector may add others as warranted based on any potential problems observed or changes in personnel.