February 29, 2024, Adult Family Home Forum Q and As

Q1. Power Outage

Can you clarify if in a power outage the provider must adhere to the inside temperature of the home to not be lower than 65 during the day and 60 at night. If the temperature does drop would the provider need to have a plan where to take the residents like a hotel or warming center or can a provider just ensure clients are wearing warm clothes and have extra blankets?

Refer to below WAC requirement. If the outage is lasting several hours and residents are uncomfortable, then pursue hotel short-term stay, family home stays, and/or warming centers. If not several hours, ensure resident comfort with warm clothing and fluids, extra blankets, and use of fireplaces or generator backup systems (if home has them). If you use space heaters in power outages for emergency purposes, make sure they are UL-certified for safety will not cause fires. Monitor use for resident, staff, and AFH safety. It depends on what the severe inclement situation is providers may be dealing with at the time. Prepare your emergency plan places to temporarily take residents for comfort, warmth, and safety. Hotels may be filled, and providers may have to go to another geographical. It's a good recommendation to assess and update your plans now.

WAC 388-76-10775

Temperature and ventilation.

The adult family home must:

(1) Ensure that the maximum and minimum temperature of any room used by a resident is comfortable for the resident and does not compromise the resident's health and safety.

(2) At a minimum, keep room temperature at:

(a) Sixty-eight degrees Fahrenheit or more during waking hours; and

(b) Sixty degrees Fahrenheit or more during sleeping hours.

(3) Provide ventilation in the home to ensure the health and comfort of each resident is met.

Q2. Visitor Restriction

Could you please clarify if a power of attorney, family member, or guardian has the authority to restrict visitors? My understanding is that visitors can only be banned when a vulnerable adult is under protection by court order. Is this understanding accurate? What if the family have a lot of court cases like forgery, DUI, can I limit their visit for like 1 hour only. The resident is hospice and has Dementia. Wasn't there a law recently I read that anyone has the right to see who

they want to no matter what the POA says. Some family members refuse to let other family member see someone.

See RCW 70.129.090, WAC 388-76-10401 and WAC 388-76-10595. Residents are allowed to have visitors at any time with the resident's consent and any modification must meet the criteria in WAC. This includes, but is not limited to, trying less restrictive alternatives, and documenting the modification in the resident's care plan (WAC 388-76-10401). Visits may only be limited when the limitation is to protect the rights or safety of the residents or others in the home and must be documented under WAC 388-76-10401 (WAC 388-76-10595). Resident has the right to choose visitors and visitation.

Q3. Provider Visitors

Could you please clarify the policy regarding visitors of providers in licensed buildings? Specifically, is it permissible for visitors to be upstairs away from residents without undergoing background checks? My understanding is that regardless of their location within the licensed building, visitors of entity representatives, staff members, owners, or family members of owners, friends of owner must undergo background checks, unless the alternate space has a separate address.

WAC does not require background checks on visitors to the home, but the provider is responsible for actively supporting the safety of each resident (WAC 388-76-10400). See WAC 388-76-10161 for information on who is required to have a background check. The provider can monitor and be aware where their visitors are in the adult family home who are visiting the provider and not residents.

Q4. Annual Inspections

How do you decide which house to conduct an annual inspection? Some homes have not had inspections for three years.

Thank you for asking. Residential Care Services is actively conducting unannounced inspections and making progress re-establishing its inspection interval. There are many AFHs in our state, the highest of any program regulated.so will take another year and then some to re-establish the interval. The Division did conduct infection control inspections in each home during the pandemic.

Providers can review the inspection process in RCS' Standard Operation Procedures @ https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/SOP/Chapter%2012%20-%20AFH.pdf. If you have not had an unannounced inspection, we encourage you to use the AFH statutes, regulations, and standard operating procedures to assess your home for compliance. Feel free to reach out to your AFH Field Manager, Regional Administrator, and Field Service Administrator to answer any of your questions and understanding the statutes and requirements.

WAC 388-76-10912

Inspection timelines.

(1) In response to the COVID-19 pandemic, the governor suspended the requirement for the department to conduct full licensing inspections of adult family homes required by RCW 70.128.070 (2)(b).

(2) During the suspension of the full licensing inspection requirements, the department continued to conduct complaint investigations in adult family homes when it became aware of information that indicated an immediate threat to resident health and safety may exist.

(3) The department must prioritize and resume full licensing inspections of adult family homes affected by the suspension of the inspection requirements by applying the following criteria collectively:

(a) The department has identified an ongoing threat to the health and safety of residents through one or more reported complaints, previous inspections, or previous investigations;

(b) Whether the adult family home has had a remedy imposed in the last 24 months; and

(c) The length of time since the last full licensing inspection of the adult family home.

(4) The department must conduct a full licensing inspection for adult family homes licensed after the reinstatement of RCW 70.128.070 (2)(b) in accordance with the schedule set by that section.

Q5. Provider Home Tool Search

It was mentioned that ALTSA will be revising the provider home tool search. The current one does not show private pay only homes unless the searcher clicks on a special box that is easily missed. Thus, private pay only homes have an extreme disadvantage. We all equally pay the same bed fees can this be changed/addressed.

Thank you for your question. We have shared it with our Home and Community Services leadership.

Q6. TB

Can a QuantiFERON-TB Gold plus test be done a few months prior to being employed in an AFH and sufficient or in lieu of a 2 step PPD? I thought the QuantiFERON-TB Gold plus test is okay to bring to other AFH if apply for another home.

No. TB Testing must be done within 3 days of hire. Testing methods include the intradermal (Mantoux) administration (**skin**) **OR** IGRA (**blood test**). See regulatory references below:

WAC 388-76-10265, TB Testing Required:

The adult family home must develop and implement a system to ensure the following persons have tuberculosis testing within three days of employment: Provider, entity representative, resident manager, caregiver, staff and any student or volunteer providing resident care.

WAC 388-76-10270, TB Testing method- Required:

The adult family home must ensure that all tuberculosis testing is done through either:
(1) Intradermal (Mantoux) administration with test results read:
(a) Within forty-eight to seventy-two hours of the test; and
(b) By a trained professional; or
(2) A blood test for tuberculosis called interferon-gamma release assay (IGRA).

Can the blood test replace the 2 step TB test?

The two approved testing methods are skin and blood- **See WAC 388-76-10270**, which states either method is acceptable.

How often can a staff repeat a TB blood test?

Testing is required within three days of hire per **WAC 388-76-10265**. Adult family homes do not require annual testing, as other facility types. A repeat blood test is not required unless there is suspicion of exposure (per the AFH's policies and system to prevent the spread of infection- **WACs 388-97-10265, 388-76-10255, & 388-76-10260**) or per the recommendations of the person's health care provider, per **WAC 388-76-10290**.

The chest x-ray test is good for how long until you can get another one.

Though the AFH is required to keep the chest x-ray findings/report 18 months after the date an employee either quits or is terminated per **WAC 388-76-10310, a chest x-ray** is only required when a person has a positive TB test result within 7 days (which is required within three days of employment) **per WAC -10265 and -10290.** At the time of the positive TB results and x-ray, the AFH would need the recommendations of the health care provider (who may require another x-ray). An x-ray would be required within 7 days of each positive TB test.

If one turns negative on a two-step TB test, and hospital says no need for two-step, please advise.

Long Term Care facility settings such as Adult Family Homes have different regulations than hospitals, thus the AFH must follow the AFH regulations. You may share the regulatory reference with the hospital:

WAC 388-76-10285, Tuberculosis—Two step skin testing.

Unless the person meets the requirement for having no skin testing or only one test, the adult family home, choosing to do skin testing, must ensure that each person has the following two-step skin testing:

(1) An initial skin test within three days of employment; and

(2) A second test done one to three weeks after the first test.

The requirements for only requiring the one-step test:

WAC 388-76-10280, Tuberculosis—One test.

The adult family home is only required to have a person take one test if the person has any of the following:

(1) A documented history of a negative result from a previous two step test done no more than one to three weeks apart; or

(2) A documented negative result from one skin or blood test in the previous twelve months.

I am from east Africa, almost all time the skin test result is positive so in the case can we just do the blood test?

Per **WAC 388-76-10265**, TB testing is *required* within 3 days of employment.

There are two testing methods that are accepted for TB- Skin (Intradermal) and blood (interferon-gamma release assay or IGRA) per **WAC 388-76-10270**.

Per **WAC 388-76-10300**, a person may decline a skin test, thus require obtaining a blood test.

Per **WAC 388-76-10275**: If you have a documented history of a previous positive skin test with ten or more millimeters induration **OR** a documented history of a previous positive blood test **OR** documented evidence of adequate therapy for active disease **OR** Documentation of completion of treatment for latent tuberculosis infection preventative therapy, then TB testing is not required. The facility will need to make sure that the TB is not currently active and not potentially expose the residents and follow their policy on TB and infection prevention and control. Contacting the medical provider that is monitoring the TB history is required if it was positive, in addition to a chest x-ray within 7 days and symptom evaluation.

Regarding tuberculosis testing, do staff that have a history of positive PPD, and a negative chest x-ray must redo the test again as a new hire? Medical professionals usually say no and to avoid the risk of repeated radiation exposure.

Per AFH regulations under **WAC 388-76-10265**, Testing required- TB testing is *required* within 3 days of employment.

In some places, they only have the blood base TB test. Is this, ok? Is it ok with blood base TB test only one time?

Yes, the interferon-gamma release assay (IGRA) is one of the approved TB testing methods, which is required only one time.

Can you explain the requirements: TB one-test vs. two vs. an x-ray at hiring and annual.

TB One-Test:

Per **WAC 388-76-10280**, the AFH is only required to have a person take one test if the person has 1) A documented history of a negative result from a previous 2-step done no more than 1-3 weeks apart (the required time frame); OR 2) A documented negative result from one skin or blood test in the *previous 12 months*.

TB- Two Step Testing (skin only):

Per **WAC 388-76-10285**, if the AFH chooses skin testing as the TB testing method, each person must have the following two-step skin testing: 1) an initial skin test within three days of employment; and 2) a second test done one to three weeks after the first test. This method is required if the person does not meet the requirement for no skin testing (**WAC 388-76-10275**) or one test (**WAC 388-76-10280**).

X-ray:

The AFH regulations mention the requirement of an x-ray in **WAC 388-76-10290**, **-10305**, and **-10310**.

- **WAC 388-76-10290, Tuberculosis- Positive test result**: An **x-ray** is required within seven days of a positive skin or blood test (**WAC 388-76-10290**). Also in WAC **-10290**, the AFH must follow the recommendation of the person's health care provider. This may include an additional x-ray at another date/time depending on the provider's instruction.
- **WAC 388-76-10305**, **Tuberculosis- Reporting required**: An AFH must report any person with TB symptoms or a **positive chest x-ray** to the appropriate health care provider or public health provider.
- **WAC 388-76-1310, Tuberculosis- Test records:** An AFH must keep the records of tuberculin test results, **reports of x-ray findings,** and any physician or public health provider orders in the AFH;

Annual:

There are currently no annual requirements for TB testing in the AFH setting.

Is TB testing still required if our hire had a chest x-ray prior to hiring. Example: A new hire gets an x-ray. Is TB testing still required?

Per AFH regulations under **WAC 388-76-10265**, Testing required- TB testing is *required* within 3 days of employment. An x-ray is only required when the TB test is positive and must be completed within 7 days.

TB testing, can it be chest X-ray.

Refer to WAC 388-76-10290 requirement that chest x-rays are required in seven days if there a + TB test.

WAC 388-76-10290

Tuberculosis—Positive test result.

When there is a positive result to tuberculosis skin or blood testing the adult family home must:

(1) Ensure that the person has a chest X-ray within seven days;

(2) Ensure each resident or employee with a positive test result is evaluated for signs and symptoms of tuberculosis; and

(3) Follow the recommendation of the person's health care provider.

Q7. Fall Forum Q & A Location

Where can we find the Q&As from last fall?

The Adult Family Council posts them on their website. Please contact Karen Cordero, karen@adultfamilyhomecouncil.org if you need assistance. Thank you.

Q8. DDA Contract Change if Nurse Delegators

Under a Medicaid DDA contract when the AFH changes nurse delegators can the AFH do so with the resident guardian's consent only. Some case managers are saying the DDA residents need to okay it first. Not sure why as my DDA residents don't understand the need or concept of what the nurse delegator responsibilities are.

For DDA and HCS clients, the nurse delegation consent is to be signed by the client or authorized representative depending on who has signature authority. WAC 246-840-920 below defines who is an authorized representative. WAC 246-840-930(10)(b) below addresses the written consent information. The entire WAC has been provider to refresh on delegation requirements. Email any questions you have about nurse delegation to: nursedelegation@dshs.wa.gov.

WAC 246-840-920

Definitions.

The following definitions apply to WAC **246-840-910** through **246-840-970**.

(1) "Authorized representative" means a person allowed to provide written consent for health care on behalf of a patient who is not competent to consent. Such person shall be a member of one of the classes of persons as directed in RCW **7.70.065**.

WAC 246-840-930

Criteria for delegation.

(1) Before delegating a nursing task, the registered nurse delegator decides the task is appropriate to delegate based on the elements of the nursing process: ASSESS, PLAN, IMPLEMENT, EVALUATE.

ASSESS

(2) The setting allows delegation because it is a community-based care setting as defined by RCW **18.79.260** (3)(e)(i) or an in-home care setting as defined by RCW **18.79.260** (3)(e)(ii).

(3) Assess the patient's nursing care needs and determine the patient's condition is stable and predictable. A patient may be stable and predictable with an order for sliding scale insulin or terminal condition.

(4) Determine the task to be delegated is within the delegating nurse's area of responsibility.

(5) Determine the task to be delegated can be properly and safely performed by the nursing assistant or home care aide. The registered nurse delegator assesses the potential risk of harm for the individual patient.

(6) Analyze the complexity of the nursing task and determine the required training or additional training needed by the nursing assistant or home care aide to competently accomplish the task. The registered nurse delegator identifies and facilitates any additional training of the nursing assistant or home care aide needed prior to delegation. The registered nurse delegator ensures the task to be delegated can be properly and safely performed by the nursing assistant or home care aide.

(7) Assess the level of interaction required. Consider language or cultural diversity affecting communication or the ability to accomplish the task and to facilitate the interaction.

(8) Verify that the nursing assistant or home care aide:

(a) Is currently registered or certified as a nursing assistant or home care aide in Washington state without restriction;

(b) Has completed both the basic caregiver training and core delegation training before performing any delegated task;

(c) Has evidence as required by the department of social and health services of successful completion of nurse delegation core training;

(d) Has evidence as required by the department of social and health services of successful completion of nurse delegation special focus on diabetes training when providing insulin injections to a diabetic client; and

(e) Is willing and able to perform the task in the absence of direct or immediate nurse supervision and accept responsibility for their actions.

(9) Assess the ability of the nursing assistant or home care aide to competently perform the delegated nursing task in the absence of direct or immediate nurse supervision.

(10) If the registered nurse delegator determines delegation is appropriate, the nurse:

(a) Discusses the delegation process with the patient or authorized representative, including the level of training of the nursing assistant or home care aide delivering care.

(b) Obtains written consent. The patient, or authorized representative, must give written, consent to the delegation process under chapter **7.70** RCW. Documented verbal consent of patient or authorized representative may be acceptable if written consent is obtained within 30 days; electronic consent is an acceptable format. Written consent is only necessary at the initial use of the nurse delegation process for each patient and is not necessary for task additions or changes or if a different nurse, nursing assistant, or home care aide will be participating in the process.

PLAN

(11) Document in the patient's record the rationale for delegating or not delegating nursing tasks.

(12) Provide specific, written delegation instructions to the nursing assistant or home care aide with a copy maintained in the patient's record that includes:

(a) The rationale for delegating the nursing task;

(b) The delegated nursing task is specific to one patient and is not transferable to another patient;

(c) The delegated nursing task is specific to one nursing assistant or one home care aide and is not transferable to another nursing assistant or home care aide;

(d) The nature of the condition requiring treatment and purpose of the delegated nursing task;

(e) A clear description of the procedure or steps to follow to perform the task;

(f) The predictable outcomes of the nursing task and how to effectively deal with them;

(g) The risks of the treatment;

(h) The interactions of prescribed medications;

(i) How to observe and report side effects, complications, or unexpected outcomes and appropriate actions to deal with them, including specific parameters for notifying the registered nurse delegator, health care provider, or emergency services;

(j) The action to take in situations where medications and/or treatments and/or procedures are altered by health care provider orders, including:

(i) How to notify the registered nurse delegator of the change;

(ii) The process the registered nurse delegator uses to obtain verification from the health care provider of the change in the medical order; and

(iii) The process to notify the nursing assistant or home care aide of whether administration of the medication or performance of the procedure and/or treatment is delegated or not;

(k) How to document the task in the patient's record;

(l) Document teaching done and a return demonstration, or other method for verification of competency; and

(m) Supervision shall occur at least every 90 days. With delegation of insulin injections, the supervision occurs at least weekly for the first four weeks and may be more frequent.

(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.

IMPLEMENT

(14) Delegation requires the registered nurse delegator teach the nursing assistant or home care aide how to perform the task, including return demonstration or other method of verification of competency as determined by the registered nurse delegator.

(15) The registered nurse delegator is accountable and responsible for the delegated nursing task. The registered nurse delegator monitors the performance of the

task(s) to assure compliance with established standards of practice, policies and procedures and appropriate documentation of the task(s).

EVALUATE

(16) The registered nurse delegator evaluates the patient's responses to the delegated nursing care and to any modification of the nursing components of the patient's plan of care.

(17) The registered nurse delegator supervises and evaluates the performance of the nursing assistant or home care aide, including direct observation or other method of verification of competency of the nursing assistant or home care aide. The registered nurse delegator reevaluates the patient's condition, the care provided to the patient, the capability of the nursing assistant or home care aide, the outcome of the task, and any problems.

(18) The registered nurse delegator ensures safe and effective services are provided. Reevaluation and documentation occur at least every 90 days. Frequency of supervision is at the discretion of the registered nurse delegator and may be more often based upon nursing assessment.

(19) The registered nurse must supervise and evaluate the performance of the nursing assistant or home care aide with delegated insulin injection authority at least weekly for the first four weeks. After the first four weeks the supervision shall occur at least every 90 days.

Q9. Forum PowerPoint Access

May I please have a copy of the PowerPoint presentation for reference?

The Adult Family Council emails to all attendees following the forum. Please contact Karen Cordero, karen@adultfamilyhomecouncil.org if you did not receive a copy. Thank you.

Q10. Hazardous Chemicals

Is toothpaste considered a hazardous chemical?

Can a nurse assess and sign a document to say that the resident is safe around cleaning products so that the AFH can leave the cleaners, etc., unlocked.

Wasn't there a specific sanitizer we had to use that was safe for residents?

We have a client who like buying cleaning supplies and collect them stating it for his LLC, He has a private room, and he has refused to give to staff for them to be locked in. He says it's his rights as he's not harming anyone or himself. Can he keep them in his room?

The home must determine what is toxic and hazardous. Labels on products and substances usually provide information that help consumers recognize potential

dangers and include information about storage. Assess the resident for safety and record in negotiated care plan. If safe, offer options like a lockable box to store in the resident's room.

The Residential Care Services Behavioral Health Support Team has provided consultation on the issue quite a bit. RCS emphasizes to providers that they can't just assume the resident is unsafe. There was a resident whose rights were being restricted just to be on the safe side, but they very much were able and wanted to do their own cleaning.

Q11. Bed Rails and Medical

Private Pay- I have doctor's order to have bedside rails during bedside care only. Primary Care Physician is okay even without PT/OT assessment. I would like a clarification. We will need a doctor's order and a PT/OT evaluation to use any equipment?
You said PT/OT with HCS for bed rails or medical equipment. How can we reach them?
My resident came in with a wheelchair and a walker provided by her son, DPOA. In this case, do I need a PT evaluation, or no need, since the son is her DPOA and decided that it is safe for her mom to use them? Just need your opinion on this please.
Use to be PT but they changed it to an RN. Medicare will not pay for someone to come out just for an eval for a device.
Do you know of any brands of 1/4 bed rails that we are not allowed to use because of a recall?
Medical devices - Who is the qualified person to complete the "assessment" for the use of bedrails? WAC 10335 (6a) states HCS CM. AFH is hearing a physical therapist must complete the assessment but cannot find a WAC that states this. Providers are being told the nurse delegator can complete, but nurse delegators are told they cannot.

WAC 388-76-10000

Definitions.

"Medical device" as used in this chapter, means any piece of medical equipment used to treat a resident's assessed need.

(1) A medical device is not always a restraint and should not be used as a restraint;

(2) Some medical devices have considerable safety risks associated with use; and

(3) Examples of medical devices with known safety risks when used are transfer poles, Posey or lap belts, and side rails.

WAC 388-76-10650 Medical Devices requires that providers must assess resident safety risks, complete a device assessment, do required notifications, include in the

negotiated care plan how a resident will use the device, and must properly install the device. It requires a qualified assessor to do the assessments for medical devices for private pay residents and an authorized case manager if the Department pays for resident care and services. This WAC does not require physician orders. The provider will still need to meet the assessment requirements if they do have an order. The in is not an assessment. A physician can conduct an assessment as a qualified assessor. Registered Nurse Delegators can assess if they meet the qualified assessor qualification under WAC 388-76-10345. They cannot do the required evaluation for bedrails or siderails for Medicaid Long Term Services and Supports recipients.

A wheelchair is a mechanical device and would require an assessment to ensure its safe, not a restraint, and fits the resident. The provider will need to meet the requirements of WAC 388-76-10650. Subsection (2)(b) requires the provider to provide the resident and their family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device.

If use of bed rails or side rails is being considered for resident receiving Medicaid, a physical therapist or occupational therapist must complete (DSHS Form 13-906) to determine a recommendation for bed rails and side rails. This evaluation is specific for Medicaid Long Term Services and Supports recipients, not residents privately paying. The PT or OT therapist will evaluate what specific medical or functional need for bed rails or side rails is requested, including related accessories. Use the form link to note other evaluation questions asked. The provider must return the completed form to the client's primary healthcare provider and the client's case worker. If Medicare denies evaluation, and the client is receiving Medicaid, Apple Health has evaluation coverage if the PT/OT therapists are in the client's Apple Health Managed Care network. You can reach them through the network.

Refer to Residential Care Services Dear Provider letter, ALTSA: AFH #2022-007, issued February 25, 2022, for information about certain bedrail recalls:

https://www.dshs.wa.gov/sites/default/files/ALTSA/rcs/documents/multiple/022-02-25-1.pdf

Additional Resources: Refer to the attachments at the end of this question for information on rail recalls, DSHS' bedrail policy, and bedrail safety. The rail recall document provides the brand names associated with the 2021 recall for adult portable bedrails, which the ¼ bed rail size was part of this category of bed rails. The DSHS policy can found as an appendix in Chapter 3 of ALTSA's Long Term Care Manual. This is the assessment and care planning chapter.

WAC 388-76-10650

Medical devices.

(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.

(2) Before a medical device with a known safety risk is used by a resident, the home must:

(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;

(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;

(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and

(d) Ensure the medical device is properly installed.

WAC 388-76-10345

Assessment—Qualified assessor—Required.

The adult family home must ensure the person performing resident assessments is:

(1) A qualified assessor; or

(2) For a resident who receives care and services paid for by the department, an authorized department case manager.

WAC 388-76-10150

Qualifications—Assessor.

(1) The adult family home must ensure that an assessor, except for an authorized department case manager, performing an assessment for any resident meets the following qualifications:

(a) A master's degree in social services, human services, behavioral sciences or an allied field and two years social service experience working with adults who have functional or cognitive disabilities; or

(b) A bachelor's degree in social services, human services, behavioral sciences or an allied field and three years social service experience working with adults who have functional or cognitive disabilities; or

(c) Have a valid Washington state license to practice as a nurse under chapter **18.79** RCW and three years of clinical nursing experience; or

(d) Is currently a licensed physician, including an osteopathic physician, in Washington state.

(2) The home must ensure than an assessor who meets the requirements of subsections (1)(a), (b), or (c) of this section does not have unsupervised access to any resident unless the assessor has:

(a) A current criminal history background check; and

(b) Has no disqualifying criminal convictions or pending criminal charges under chapter **388-113** WAC; and

(c) None of the negative actions listed in WAC **388-76-10180** are applicable to the assessor.


Detailed Information Regarding Recall.pdf


DSHS ALTSA HCS Bed Rail Policy.pdf


A-Guide-to-Bed-Safety-Bed-Rails-in-Hospit

Q12. Delegation for INR

Can we do INR blood work with delegation?

INR testing is not allowed. The only piercing of the skin allowed for delegation or for the LTCW is blood glucose monitoring and insulin administration. Injection administration of medication for weight loss is not permitted. For example, Ozempic. Refer to WAC 246-840-930 (13):

WAC 246-840-930

(13) The administration of medications may be delegated at the discretion of the registered nurse delegator, including insulin injections. Any other injection (intramuscular, intradermal, subcutaneous, intraosseous, intravenous, or otherwise) is prohibited. The registered nurse delegator provides to the nursing assistant or home care aide written directions specific to an individual patient.

Email any questions you have about nurse delegation to: nursedelegation@dshs.wa.gov.

Q13. Outbreak Reporting

Does it mean if you have one COVID case in the AFH you don't need to report since it's not an outbreak?

- The AFH must report all COVID-19 ***cases*** to their Local Health Jurisdiction
  - WAC 246-101-101/Notifiable Conditions

- COVID-19 ***outbreaks*** are reportable to the Residential Care Services hotline.
  - *WAC 388-76-10225/Reporting Requirement (3) Whenever an outbreak of suspected food poisoning or communicable disease occurs, the adult family home must notify (b) The departments complaint toll-free hotline number.*

- AFHs may ***voluntarily*** report all COVID-19 cases to the hotline if they choose.

WHAT THIS MEANS: The AFH is responsible for investigating and determining if a COVID-19 outbreak is occurring in the home. The AFH should apply the updated CORHA/CSTE COVID-19 outbreak definition when making this determination:

- ≥2 cases of probable* or confirmed COVID-19 among residents, with epi-linkage **OR**
- ≥2 cases of suspect†, probable* or confirmed COVID-19 among HCP†† **AND** ≥1 case of probable* or confirmed COVID-19 among residents, with epi-linkage **AND**
- no other more likely sources of exposure for at least 1 of the cases

CORHA is the Council for Outbreak Response, Health Associated Infections

CSTE is the Council of State and Territorial Epidemiologists

CORHA/CSTE provides **epi-linkage** definitions as:

Epi-linkage among residents is defined as overlap on the same unit or ward, or other patient care location (e.g., radiology suite), or having the potential to have been cared for by common HCP **within a 7-day period** of each other. Determining epi-linkages requires judgment and may include weighing evidence whether or not patients had a common source of exposure.

Epi-linkage among HCP is defined as having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the **7 days prior to the onset** of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility. Determining epi-linkages requires judgment and may include weighing evidence whether or not transmission took place in the facility, accounting for likely sources of exposure outside the facility.

INTERPRETATION: Applying the CORHA/CSTE COVID-19 Outbreak Definition:

- A first resident **case** positive would **NOT** be mandated as reportable to the CRU as one case does not constitute an outbreak.
- If a second resident COVID-19 case *with epi-linkage occurs within 7 days* of the first case, this would constitute a COVID-19 outbreak and **IS** reportable to the CRU.
- Staff positive COVID-19 cases **alone** are no longer defined as an outbreak.
    - There must be at least two staff positive cases and **ONE resident** positive with epi-linkage to one or more of the staff cases to meet the definition of an outbreak.

Q14. DPOA Filing

Where can we get help with filing DPOA, from finding the right paperwork to having a notary come to home for immobile residents. I have looked for a suitable one, Spanish speaking. My resources are limited to Google.

Northwest Justice/Washington Law Help for tools on seeking a POA is resource: Durable power of attorney | WashingtonLawHelp.org | Helpful information about the law in Washington.

Ask your regional ombuds if they have recommended resources.

Q15. Regions

What region is King County in? Didn't see any for Seattle only for Lynnwood.

King County is in Region 2.

Q16. Shoreline Field Manager

Can you go over Region 2 Field Manager for north King County (Shoreline)? Would it be Kent or Lynnwood office staff.

AFHs situated in Shoreline will typically have Renee Borque (Unit 2I, Lynnwood) as their Field Manager.

Q17. Sprinklers

Is there any way that there could be a consideration to always having 2 caregivers onsite as opposed to using sprinklers since it is so expensive and difficult to get done. (Have people who either don't respond back, or don't show up at all). I would prefer 2 people if we have more than 6 residents.

RCW 70.128.066(2)(f) requires "The home has a residential sprinkler system in place in order to serve residents who require assistance during an evacuation". The Department interprets this to mean that homes serving individuals who require assistance with evacuation must have a residential sprinkler system. Homes that serve only residents who are independent with evacuation do not require a sprinkler system. Without a legislative change to the statute, there is no option to have two caregivers instead of a sprinkler system.

Q18. Language Access

Please clarify the WAC citation regarding Resident Rights and Services and the comment on language access. How does the Provider determine what the language access needs to be?

What if the resident has dementia, a Guardian or Representative? Whose language needs to be verified.

Do we pay someone to translate if we don't speak that language? Yes.

WAC 388-76-10000

Definitions.

"Resident" means any adult living in the adult family home and who is unrelated to the provider and who receives personal or special care from the adult family home. Except

as specified elsewhere in this chapter, for decision-making purposes, the term "resident" includes the resident's surrogate decision maker acting under state law.

WAC 388-76-10130

Qualifications—Provider, entity representative, and resident manager.

The adult family home must ensure that the provider, entity representative on behalf of an entity provider, and resident manager have the following minimum qualifications:

(6) Have the ability to communicate with residents in their primary language, including through a qualified person on-site or readily available at all times, or other reasonable accommodations, such as a language line;

Q19. <u>Residential Care Services Infection Prevention Control and Emergency Preparedness Team</u>

It wasn't mentioned about the infection control committee/group doing in home consultations...Feb 8th (?)

Residential Care Service announced February 8, 2024, in a Dear Provider letter about its new team.

Jamie Ford, MA, BS, LPN is hired to replace Katherine Ander's RCS IPC Specialist position. Jamie will serve as an infection control subject matter expert and point of contact for IPC standards in the long-term care regulatory setting. Jamie is responsible for internal and external IPC work, training, and communication.

Linda Dunn, RN will continue as the Regulatory QA Training Program Manager – Infection Control & Emergency Preparedness. Linda is the RCS Nurse IPC Specialist and Local Health Jurisdiction point of contact. Linda will continue to answer IPC questions and provide training to internal and external stakeholders and partners.

Richard Freed is hired as the RCS Emergency Preparedness Coordinator. This position is responsible for, and acts as the liaison between, RCS and other state and federal departments, emergency management agencies, organizations, and groups on all program matters. This position works in conjunction with the IPC specialists. He presented in the Winter 2024 forum.

This team has a mailbox: ipc.epteam@dshs.wa.gov. Jamie Ford and Linda Dunn will respond specific Infection Control and Prevention inquiries. Richard Freed will be happy to assist you for emergency preparedness.

Q20. <u>Forum Non-Compliance Data</u>

Are the citations (forum) from 11/1/2023 and 1/29/2024.

Yes, those were the highest cited WACs from November 2023 to February 2024. We present the time period from the last forum.

Q21. Caregiver Specialty Training

Does my caregiver only need certificates for the residents that I have? I currently don't have a DDA resident, so my caregiver doesn't need this to be left alone. Is this correct.

The DD specialty training is required if the adult family home is providing care and services to residents with developmental disabilities. Staff are required once admit a resident with developmental disabilities. Refer to WAC 388-112-0400.

WAC 388-112A-0400

What is specialty training and who is required to take it?

(1) Specialty training refers to approved curricula that meets the requirements of RCW **18.20.270** and **70.128.230** to provide basic core knowledge and skills to effectively and safely provide care to residents living with mental illness, dementia, or developmental disabilities.

(2) Specialty training classes are different for each population served and are not interchangeable. Specialty training curriculum must be DSHS developed, as described in WAC **388-112A-0010**(3), or DSHS approved.

(a) In order for DSHS to approve a curriculum as a specialty training class, the class must use the competencies and learning objectives in WAC **388-112A-0430**, **388-112A-0440**, or **388-112A-0450**.

(i) Training entities that currently use classes approved as alternative curriculum for specialty training must update and submit their curricula for approval prior to June 30, 2018.

(ii) After July 1, 2018, training entities must not use classes approved as alternative curriculum for specialty training that are not using the competencies and learning objectives in WAC **388-112A-0430**, **388-112A-0440**, or **388-112A-0450** to meet the specialty training requirement.

(b) Curricula approved as specialty training may be integrated with basic training if the complete content of each training is included.

(3) Assisted living facility administrators or their designees, enhanced services facility administrators or their designees, adult family home applicants or providers, resident managers, and entity representatives who are affiliated with homes that service residents who have special needs, including developmental disabilities, dementia, or mental health, must take one or more of the following specialty training curricula:

(a) Developmental disabilities specialty training as described in WAC **388-112A-0420**;

(b) Dementia specialty training as described in WAC **388-112A-0440**;

(c) Mental health specialty training as described in WAC **388-112A-0450**.

(4) All long-term care workers including those exempt from basic training who work in an assisted living facility, enhanced services facility, or adult family home who serve residents with the special needs described in subsection (3) of this section, must take a class approved as specialty training. The specialty training applies to the type of residents served by the home as follows:

(a) Developmental disabilities specialty training as described in WAC **388-112A-0420**.

(b) Dementia specialty training as described in WAC **388-112A-0440**; and

(c) Mental health specialty training as described in WAC **388-112A-0450**.

(5) Specialty training may be used to meet the requirements for the basic training population specific component if completed within one hundred twenty days of the date of hire.

(6) For long-term care workers who have completed the seventy-five-hour training and do not have a specialty training certificate that indicates completion and competency testing, the long-term care worker must complete specialty training when employed by the adult family home, enhanced services facility, or assisted living facility that serves residents with special needs.

18) **"Expanded specialty training"** means optional curricula that provide caregivers with advanced knowledge and skills to provide person-centered care to clients or residents living with conditions other than developmental disabilities, dementia, and mental health. The optional expanded specialty training may include such topics as traumatic brain injury, diabetes care, and bariatric care. The optional expanded specialty training curricula must be DSHS developed and based on competencies and learning objectives established by the department.