

Washington State Department of Health

Tuberculosis Services

Washington State Tuberculosis Laws

Washington
Administrative
Code (WAC)
&
Revised Code of
Washington (RCW)

September 1

2014

Provides a listing of all WACs and RCWs related to tuberculosis, under the search criteria “tuberculosis”, “TB”, and “tuberculin.” When the WAC/RCW is not specifically related to TB, but is referred to within, the text has been highlighted for quick reference.

Table of Contents

WAC

Department of Early Learning	4
Minimum Licensing Requirements for Child Care Centers	4
Licensed Family Home Child Care Standards	5
Licensed School Age Child Care Standards	8
Health Care Authority.....	11
Client Not in Own Home—Institutional Medical	11
Department of Health	11
Communicable and Certain Other Diseases	11
Notifiable Conditions	15
Contagious Disease—School Districts and Childcare Centers	17
Tuberculosis—Prevention, Treatment and Control.....	19
Hospital Licensing Regulations.....	24
Private Psychiatric and Alcoholism Hospitals	24
Private Alcohol and Chemical Dependency Hospitals	26
Childbirth Centers	28
Ambulatory Surgical Facilities	31
In Home Services Agencies	31
Residential Treatment Facilities.....	32
Medical Test Site Rules	33
Nursing Pool.....	34
Department of Labor and Industries	34
Recordkeeping and Reporting.....	35
Safety Standards for Firefighters.....	38
Safety Standards for Agriculture.....	40
Respirators	42
Board of Pilotage Commissioners.....	42
Pilotage Rules.....	42
Department of Social and Health Services.....	48
Home and Community Service Programs	48

Adult Family Homes Minimum Licensing Requirements	49
Assisted Living Facility Licensing Rules	53
Nursing Homes.....	55
Emergency Respite Centers	59
Licensing Requirements for Child Foster Homes, Staff Residential Homes, Group Residential Facilities and Child-Placing Agencies	61
Minimum Licensing Requirements for Overnight Youth Shelters	64
Chemical Dependency Services.....	66
Superintendent of Public Instruction	79
Rules for the Provision of Special Education.....	79
Department of Retirement Systems.....	81
Law Enforcement Officers and Firefighters Retirement Systems.....	81
RCW	
Department of Health	82
State Government—Executive.....	82
Public Health and Safety	86

Department of Early Learning

Minimum Licensing Requirements for Child Care Centers.

WAC 170-295-1120

What are the tuberculosis (TB) testing requirements for the staff?

- (1) Each employee and volunteer must have the results of a one step Mantoux TB skin test prior to starting work.
- (2) New employees and volunteers do not need a TB skin test if they have written proof of:
 - (a) A negative Mantoux TB test in the twelve months prior to you hiring them;
 - (b) A previously positive Mantoux TB test with documented proof of treatment or a negative chest X ray;or
 - (c) Medication therapy to treat TB.
- (3) Your staff and volunteers must be retested for TB when you are notified that any of the staff or volunteers have been exposed to TB. They must comply with the direction of the local health jurisdictions.

WAC 170-295-7050

What personnel records and policies must I have?

- (1) Each employee and volunteer who has unsupervised access to a child in care must complete the following forms on or before their date of hire:
 - (a) An application for employment on a form prescribed by us, or on a comparable form approved by the department; and
 - (b) A background check form.
- (2) You must submit the background check form to us within seven calendar days of the employee's first day of work. The form authorizes a criminal history background inquiry for that person.
- (3) Until the background check results are returned and show the employee to not be disqualified, you must not leave the employee unsupervised with the children.
- (4) We discuss the information on the background check form with you, the director, or other person responsible for the operation of the center, such as a human resources professional, if applicable.
- (5) If you employ five or more people you must have written personnel policies. These policies must describe staff benefits, if any, and duties and qualifications of staff.
- (6) You must maintain a system of record keeping for personnel. In addition to the other requirements in this chapter, you must keep the following information on file on the premises for yourself, each staff person and volunteer:
 - (a) An employment application, including work and education history;
 - (b) Documentation that a background check form was submitted;
 - (c) A copy of the department notification of background clearance authorization.
 - (d) Written documentation of trainings and meetings such as but not limited to:
 - (i) Orientation;
 - (ii) On-going trainings;
 - (iii) Bloodborne pathogen training (including HIV/AIDS);
 - (iv) CPR/first aid;
 - (v) Food handler's cards (if applicable);
 - (vi) STARS;
 - (vii) Staff meetings; and

(viii) Child abuse and neglect.

(e) Documentation of the results of tuberculosis (TB) testing by the Mantoux skin test prior to starting work.

(7) You must keep the following information on file for the owner of the facility:

(a) If the center is solely owned by you:

(i) A photocopy of your Social Security card that is valid for employment or verification of your employer identification number (EIN); and

(ii) A photocopy of your photo identification issued by a government entity.

(b) If the center is owned by a corporation, verification of the corporation's EIN.

(8) Training documentation must include a certificate, card, or form with a copy placed in each individual employees file that contains the:

(a) Topic presented;

(b) Number of clock hours;

(c) Date and names of persons attending; and

(d) Signature and organization of the person conducting the training.

Licensed Family Home Child Care Standards.

WAC [170-296A-1250](#)

Initial license application packet—Contents.

(1) The individual seeking an initial license under this chapter is the license applicant.

(2) A license applicant must submit a license application packet that includes:

(a) A completed department application form and copy of the applicant's orientation certificate;

(b) Copy of license applicant's current government issued photo identification;

(c) Documentation of the license applicant's high school diploma or equivalent education under WAC [170-296A-1725](#);

(d) Resume for the license applicant;

(e) References from three individuals not related to the license applicant;

(f)(i) Copy of license applicant's Social Security card pursuant to 42 U.S.C. 666 (a)(13) and RCW [26.23.150](#) regarding child support.

(ii) If the license applicant does not have a Social Security card, the applicant must provide a sworn declaration stating that he or she does not have a Social Security card.

(g) Copy of the federal Internal Revenue Service letter showing the applicant's employer identification number (EIN) if the applicant plans to employ staff;

(h) Tuberculosis test results or required documentation for the license applicant, each staff person, and household members sixteen years old or older. See WAC [170-296A-1750](#);

(i) Copy of first-aid/CPR training and HIV/AIDS training certificates for the license applicant and each staff person required to complete such training as described in WAC [170-296A-1825](#) and [170-296A-1850](#);

(j) Copy of the license applicant's state food handler permit as described in WAC [170-296A-7675](#);

(k) Completed background clearance forms for the license applicant and each staff person, household members sixteen years old and older, and anyone sixteen years and older who may have unsupervised access to the children in care;

(l) A completed noncriminal background check application form for each assistant and volunteer fourteen to sixteen years of age, and each individual age thirteen to sixteen residing in the home;

(m) Parent, staff and operation policies (handbooks). See WAC [170-296A-2350](#), [170-296A-2375](#), [170-296A-2400](#), and [170-296A-2425](#);

- (n) Floor plan, including proposed:
 - (i) Licensed space;
 - (ii) Licensed space usage;
 - (iii) Evacuation routes and emergency exits;
 - (iv) Unlicensed space;
 - (v) Licensed space used specifically for sleeping infants, if applicable; and
 - (vi) Licensed space used for sleeping children for overnight care, if applicable.
 - (o) Septic system inspection report if applicable under WAC [170-296A-1375](#);
 - (p) Well water testing report if applicable under WAC [170-296A-1400](#);
 - (q) Lead or arsenic evaluation agreement, only if the home is located in the Tacoma smelter plume under WAC [170-296A-1360](#); and
 - (r) The license fees and other fees under WAC [170-296A-1325](#).
- (3) If there will be more than one individual whose name will appear on the license, each individual license applicant must provide information required in subsection (2)(b) through (f) and (2)(h) through (k) of this section.

WAC [170-296A-1750](#)

Tuberculosis.

The applicant, and each staff person fourteen years old and older, and each household member sixteen years old and older, must provide documentation signed by a licensed health care professional of tuberculosis (TB) testing or treatment consisting of:

- (1) A negative Mantoux test (also known as a tuberculin skin test (TST)) or negative interferon gamma release assay (IGRA) completed within twelve months before license application or employment; or
- (2) A previous or current positive TST or positive IGRA with documentation within the previous twelve months:
 - (a) Of a chest X ray with negative results; or
 - (b) Showing that the individual is receiving or has received therapy for active or latent TB disease and is cleared to safely work in a child care setting. As used in this section, "latent TB" means when a person is infected with the TB germ but has not developed active TB disease.

WAC [170-296A-1975](#)

Licensee/staff qualifications and requirements table.

The following table summarizes the licensee and staff qualifications and requirements found in WAC [170-296A-1700](#) through [170-296A-1950](#), and [170-296A-7675](#). An "X" indicates a requirement.

WAC [170-296A-2075](#)

Licensee and staff records.

Records on file for the licensee and each staff person must include documentation of:

- (1) Current first aid and infant, child and adult CPR training certification;
- (2) HIV/AIDS training certification;
- (3) TB test results or documentation as required under WAC [170-296A-1750](#);
- (4) Current state food handler permit for the licensee, and for other staff if required under WAC [170-296A-7675](#)(3);
- (5) Completed background check form, or noncriminal background check form if applicable under WAC [170-296A-1225](#), and copy of the department-issued authorization;
- (6) Copy of a current government issued picture identification;

- (7) Emergency contact information;
- (8) Completed application form or resume for staff when hired;
- (9) Documentation for the licensee's and primary staff person only of:
 - (a) Basic twenty hour STARS training;
 - (b) Ongoing training completed; and
 - (c) Registration in MERIT.
- (10) Record of training provided by the licensee to staff and volunteers; and
- (11) Resume for the licensee only.

WAC 170-296A-2100

Required records for household members.

The licensee must keep the following records for household members:

- (1) Completed background check form and the department-issued clearance under chapter 170-06 WAC for each individual sixteen years old and older;
- (2) The department-issued clearance for household members age thirteen to sixteen years old under WAC 170-296A-1225; and
- (3) TB test results or documentation under WAC 170-296A-1750 for:
 - (a) Household members sixteen years old or older; and
 - (b) Any household member fourteen to sixteen years old who is an assistant or volunteer.

WAC 170-296A-2425

Staff policies.

If the licensee hires staff or uses volunteers, the licensee must have written staff policies and provide training on the policies to all staff and volunteers. Staff policies must include:

- (1) All the information in the parent/guardian handbook under WAC 170-296A-2375, except fees;
- (2) Plan for keeping staff records current including:
 - (a) Completed background check forms and department clearances;
 - (b) First aid and CPR certification;
 - (c) TB test results;
 - (d) Required training and professional development for primary staff persons; and
 - (e) Training that the licensee must provide to staff;
- (3) Job description;
- (4) Staff responsibilities for:
 - (a) Child supervision requirements;
 - (b) Guidance/discipline techniques;
 - (c) Food service practices;
 - (d) Off-site field trips;
 - (e) Transporting children;
 - (f) Preventing children's access to unlicensed space;
 - (g) Health, safety and sanitization procedures;
 - (h) Medical emergencies, fire, disaster and evacuations;
 - (i) Mandatory reporting of suspected child abuse and neglect;
 - (j) Overnight care, if applicable; and
 - (k) Staff responsibilities if the licensee is absent from the child care operation.
- (5) The licensee must keep documentation of all staff training on policies.

Licensed School Age Child Care Standards.

WAC [170-297-1710](#)

Program director.

- (1) The licensee must serve as or employ a program director who is responsible for the overall management of the child care program and operation.
- (2) The program director must have the understanding, ability, physical health, emotional stability and good judgment to meet the needs of the children in care.
- (3) **The program director must:**
 - (a) Be at least twenty-one years of age;
 - (b) Have two years' experience in management, supervision, or leadership;
 - (c) Attend a department orientation within six months of employment or assuming the position;
 - (d) **Have a TB test as required under WAC [170-297-1750](#);**
 - (e) Have a background clearance as required under chapter [170-06](#) WAC;
 - (f) Have current CPR and first-aid certification as required under WAC [170-297-1825](#);
 - (g) Complete HIV/AIDS training and annual bloodborne pathogens training as required under WAC [170-297-1850](#);
 - (h) Have a high school diploma or equivalent;
 - (i) Have a minimum of forty-five college credits (or thirty college credits and one hundred fifty training hours) in approved school-age credits as specified in the Washington state guidelines for determining related degree and approved credits; and
 - (j) Have completed twenty hours of STARS training or possess an exemption.
- (4) A program director must be on the premises as needed.
- (5) When the program director is not on-site the program director must leave a competent, designated staff person in charge. This staff person must meet the qualifications of a site coordinator and may also serve as child care staff when that role does not interfere with management and supervisory responsibilities.

WAC [170-297-1720](#)

Lead teachers.

- (1) Lead teachers may be employed to be in charge of a child or a group of children.
- (2) The lead teacher must have the understanding, ability, physical health, emotional stability and good judgment to meet the needs of the children in care.
- (3) **Lead teachers must:**
 - (a) Be eighteen years of age or older;
 - (b) Have one year experience in school-age care;
 - (c) **Have a TB test as required under WAC [170-297-1750](#);**
 - (d) Have a background clearance as required under chapter [170-06](#) WAC;
 - (e) Have current CPR and first-aid certification as required under WAC [170-297-1825](#);
 - (f) Complete HIV/AIDS training and annual bloodborne pathogens training as required under WAC [170-297-1850](#);
 - (g) Have a high school diploma or equivalent;
 - (h) Complete twenty hours of STARS training within three months of assuming the position of lead teacher;
 - (i) Complete ongoing training hours as required under WAC [170-297-1800](#);
 - (j) Have a food worker card, if applicable; and

- (k) Attend an agency orientation as required under WAC [170-297-5800](#).
- (4) Lead teachers are counted in the staff-to-child ratio.
- (5) When the site coordinator is off-site or unavailable, lead teachers may assume the duties of site coordinator when they meet the site coordinator minimum qualifications, and may also serve as child care staff when the role does not interfere with management and supervisory responsibilities.

WAC [170-297-1730](#)

Program assistants.

- (1) Program assistants may be employed to assist in program and curriculum under the direction of a lead teacher or higher.
- (2) Program assistants under eighteen years of age must not be left in charge of a group of children and may care for children only under direct, visual or auditory supervision by a lead teacher or higher.
- (3) Program assistants eighteen years of age or older may have sole responsibility for a child or group of children for a brief period of time when there is a staff person on the premises who meets the lead teacher qualifications.
- (4) Program assistants must have the understanding, ability, physical health, emotional stability and good judgment to meet the needs of the children in care.
- (5) Program assistants must:
 - (a) Be sixteen years of age or older;
 - (b) Have a TB test as required under WAC [170-297-1750](#);
 - (c) Have a background clearance as required under chapter [170-06](#) WAC;
 - (d) Have current CPR and first-aid training as required under WAC [170-297-1825](#);
 - (e) Complete HIV/AIDS training and annual bloodborne pathogens training as required under WAC [170-297-1850](#);
 - (f) Have a food worker card, if applicable; and
 - (g) Attend an agency orientation as required under WAC [170-297-5800](#).
- (6) Program assistants are counted in the staff-to-child ratio.

WAC [170-297-1735](#)

Volunteers.

- (1) The licensee may utilize volunteers who assist in the program under the direct supervision of the program implementation staff.
- (2) The volunteers must have the understanding, ability, physical health, emotional stability and good judgment to meet the needs of the children in care.
- (3) The volunteer must:
 - (a) Be sixteen years of age or older;
 - (b) Have a background check as required under chapter [170-06](#) WAC;
 - (c) Attend an agency orientation as required under WAC [170-297-5800](#);
 - (d) Have an employment application on file; and
 - (e) Have a food worker card, if applicable.
- (4) It is recommended, but not required, that volunteers have the following:
 - (a) CPR and first-aid certification;
 - (b) HIV/AIDS training and annual bloodborne pathogen training; and
 - (c) TB test.

(5) The volunteer may be counted in the staff-to-child ratio if the volunteer meets all program assistant qualifications, but must be under the direct supervision of the program implementation staff.

WAC [170-297-1750](#)

Tuberculosis.

- (1) Each staff person must provide documentation signed by a licensed health care professional of tuberculosis (TB) testing or treatment consisting of:
 - (a) A negative Mantoux test (also known as a tuberculin skin test (TST)) or negative interferon gamma release assay (IGRA) completed within twelve months before license application or employment; or
 - (b) A previous or current positive TST or positive IGRA with documentation within the previous twelve months:
 - (i) Of a chest X ray with negative results; or
 - (ii) Showing that the individual is receiving or has received therapy for active or latent TB disease and is cleared to safely work in a child care setting. As used in this section, "latent TB" means when a person is infected with the TB germ but has not developed active TB disease.
- (2) A TB test or chest X ray may not be required if it is against the health care provider's advice. Documentation that includes a health screening must be signed by the health care professional and submitted that indicates the TB test or chest X ray is not necessary.

WAC [170-297-2075](#)

Staff records.

Records for each staff person must include documentation of:

- (1) Current first aid, child and adult CPR training certification;
- (2) Bloodborne pathogens training certification;
- (3) HIV/AIDS training certification;
- (4) **TB test results or documentation as required under WAC [170-297-1750](#);**
- (5) Current state food worker card for staff if required under WAC [170-297-7675](#);
- (6) Completed background check form if applicable under WAC [170-297-1200](#) and a copy of the department-issued authorization letter;
- (7) Copy of a current government issued picture identification;
- (8) Emergency contact information;
- (9) Completed application form or resume for staff when hired;
- (10) Documentation for staff of:
 - (a) Twenty hour basic STARS training;
 - (b) Ongoing training completed; and
 - (c) Registration in MERIT;
- (11) Record of training provided to staff and volunteers.

WAC [170-297-2425](#)

Staff policies.

- (1) The child care program must have written staff policies and provide training on the policies to all staff and volunteers. Staff policies must include:
 - (a) All the information in the parent/guardian handbook under WAC [170-297-2375](#), except fees;
 - (b) **A plan for keeping staff records current including:**
 - (i) Completed background check forms and department clearance letters;

- (ii) First-aid and CPR certification;
- (iii) TB test results;
- (iv) Required training and professional development for staff persons; and
- (v) Training that the licensee must provide to staff;
- (c) Job descriptions;
- (d) Staff responsibilities for:
 - (i) Child supervision requirements;
 - (ii) Guidance/discipline techniques;
 - (iii) Food service practices;
 - (iv) Off-site field trips;
 - (v) Transporting children;
 - (vi) Health, safety and sanitization procedures;
 - (vii) Medical emergencies, fire, disaster and evacuations; and
 - (viii) Mandatory reporting of suspected child abuse and neglect.
- (2) The licensee or designee must keep documentation of all staff training on policies.
- (3) Staff policies may be integrated with program/operations policies required under WAC 170-297-2400 in a single written policy document

Health Care Authority

Client Not in Own Home – Institutional Medical.

WAC [182-513-1300](#)

Payment standard for persons in medical institutions.

- (1) "Medical institutions" include skilled nursing homes, public nursing homes, general hospitals, tuberculosis hospitals, intermediate care facilities, and psychiatric hospitals approved by the joint commission on accreditation of hospitals (JCAH).
- (2) The monthly payment standard for eligible persons in medical institutions is forty-one dollars and sixty-two cents. The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

Department of Health

Communicable and Certain Other Diseases.

WAC [246-100-040](#)

Procedures for isolation or quarantine.

- (1) At his or her sole discretion, a local health officer may issue an emergency detention order causing a person or group of persons to be immediately detained for purposes of isolation or quarantine in accordance with subsection (3) of this section, or may petition the superior court *ex parte* for an order to take the person or group of persons into involuntary detention for purposes of isolation or quarantine in accordance with subsection (4) of this section, provided that he or she:
 - (a) Has first made reasonable efforts, which shall be documented, to obtain voluntary compliance with requests for medical examination, testing, treatment, counseling, vaccination, decontamination of persons or animals, isolation, quarantine, and inspection and closure of facilities, or has determined in his or her professional judgment that seeking voluntary compliance would create a risk of serious harm;

and

(b) Has reason to believe that the person or group of persons is, or is suspected to be, infected with, exposed to, or contaminated with a communicable disease or chemical, biological, or radiological agent that could spread to or contaminate others if remedial action is not taken; and

(c) Has reason to believe that the person or group of persons would pose a serious and imminent risk to the health and safety of others if not detained for purposes of isolation or quarantine.

(2) A local health officer may invoke the powers of police officers, sheriffs, constables, and all other officers and employees of any political subdivisions within the jurisdiction of the health department to enforce immediately orders given to effectuate the purposes of this section in accordance with the provisions of RCW [43.20.050\(4\)](#) and 70.05.120.

(3) If a local health officer orders the immediate involuntary detention of a person or group of persons for purposes of isolation or quarantine:

(a) The emergency detention order shall be for a period not to exceed ten days.

(b) The local health officer shall issue a written emergency detention order as soon as reasonably possible and in all cases within twelve hours of detention that shall specify the following:

(i) The identity of all persons or groups subject to isolation or quarantine;

(ii) The premises subject to isolation or quarantine;

(iii) The date and time at which isolation or quarantine commences;

(iv) The suspected communicable disease or infectious agent if known;

(v) The measures taken by the local health officer to seek voluntary compliance or the basis on which the local health officer determined that seeking voluntary compliance would create a risk of serious harm; and

(vi) The medical basis on which isolation or quarantine is justified.

(c) The local health officer shall provide copies of the written emergency detention order to the person or group of persons detained or, if the order applies to a group and it is impractical to provide individual copies, post copies in a conspicuous place in the premises where isolation or quarantine has been imposed.

(d) Along with the written order, and by the same means of distribution, the local health officer shall provide the person or group of persons detained with the following written notice:

NOTICE: You have the right to petition the superior court for release from isolation or quarantine in accordance with WAC [246-100-055](#). You have a right to legal counsel. If you are unable to afford legal counsel, then counsel will be appointed for you at government expense and you should request the appointment of counsel at this time. If you currently have legal counsel, then you have an opportunity to contact that counsel for assistance.

(4) If a local health officer petitions the superior court *ex parte* for an order authorizing involuntary detention of a person or group of persons for purposes of isolation or quarantine pursuant to this section:

(a) The petition shall specify:

(i) The identity of all persons or groups to be subject to isolation or quarantine;

(ii) The premises where isolation or quarantine will take place;

(iii) The date and time at which isolation or quarantine will commence;

(iv) The suspected communicable disease or infectious agent if known;

(v) The anticipated duration of isolation or quarantine based on the suspected communicable disease or infectious agent if known;

(vi) The measures taken by the local health officer to seek voluntary compliance or the basis on which the local health officer determined that seeking voluntary compliance would create a risk of serious harm;

(vii) The medical basis on which isolation or quarantine is justified.

- (b) The petition shall be accompanied by the declaration of the local health officer attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.
- (c) Notice to the persons or groups identified in the petition shall be accomplished in accordance with the rules of civil procedure.
- (d) The court shall hold a hearing on a petition filed pursuant to this section within seventy-two hours of filing, exclusive of Saturdays, Sundays, and holidays.
- (e) The court shall issue the order if there is a reasonable basis to find that isolation or quarantine is necessary to prevent a serious and imminent risk to the health and safety of others.
- (f) A court order authorizing isolation or quarantine as a result of an *ex parte* hearing shall:
- (i) Specify a maximum duration for isolation or quarantine not to exceed ten days;
 - (ii) Identify the isolated or quarantined persons or groups by name or shared or similar characteristics or circumstances;
 - (iii) Specify factual findings warranting isolation or quarantine pursuant to this section;
 - (iv) Include any conditions necessary to ensure that isolation or quarantine is carried out within the stated purposes and restrictions of this section;
 - (v) Specify the premises where isolation or quarantine will take place; and
 - (vi) Be served on all affected persons or groups in accordance with the rules of civil procedure.
- (5) A local health officer may petition the superior court for an order authorizing the continued isolation or quarantine of a person or group detained under subsections (3) or (4) of this section for a period up to thirty days.
- (a) The petition shall specify:
- (i) The identity of all persons or groups subject to isolation or quarantine;
 - (ii) The premises where isolation or quarantine is taking place;
 - (iii) The communicable disease or infectious agent if known;
 - (iv) The anticipated duration of isolation or quarantine based on the suspected communicable disease or infectious agent if known;
 - (v) The medical basis on which continued isolation or quarantine is justified.
- (b) The petition shall be accompanied by the declaration of the local health officer attesting to the facts asserted in the petition, together with any further information that may be relevant and material to the court's consideration.
- (c) The petition shall be accompanied by a statement of compliance with the conditions and principles for isolation and quarantine contained in WAC [246-100-045](#).
- (d) Notice to the persons or groups identified in the petition shall be accomplished in accordance with the rules of civil procedure.
- (e) The court shall hold a hearing on a petition filed pursuant to this subsection within seventy-two hours of filing, exclusive of Saturdays, Sundays, and holidays. In extraordinary circumstances and for good cause shown, the local health officer may apply to continue the hearing date for up to ten days, which continuance the court may grant at its discretion giving due regard to the rights of the affected individuals, the protection of the public's health, the severity of the public health threat, and the availability of necessary witnesses and evidence.
- (f) The court shall grant the petition if it finds that there is clear, cogent, and convincing evidence that isolation or quarantine is necessary to prevent a serious and imminent risk to the health and safety of others.
- (g) A court order authorizing continued isolation or quarantine as a result of a hearing shall:
- (i) Specify a maximum duration for isolation or quarantine not to exceed thirty days;
 - (ii) Identify the isolated or quarantined persons or groups by name or shared or similar characteristics or circumstances;

- (iii) Specify factual findings warranting isolation or quarantine pursuant to this section;
 - (iv) Include any conditions necessary to ensure that isolation or quarantine is carried out within the stated purposes and restrictions of this section;
 - (v) Specify the premises where isolation or quarantine will take place; and
 - (vi) Be served on all affected persons or groups in accordance with the rules of civil procedure.
- (6) Prior to the expiration of a court order for continued detention issued pursuant to subsection (5) of this section, the local health officer may petition the superior court to continue isolation or quarantine provided:
- (a) The court finds there is a reasonable basis to require continued isolation or quarantine to prevent a serious and imminent threat to the health and safety of others.
 - (b) The order shall be for a period not to exceed thirty days.
- (7) State statutes, rules, and state and federal emergency declarations governing procedures for detention, examination, counseling, testing, treatment, vaccination, isolation, or quarantine for specified health emergencies or specified communicable diseases, including, but not limited to, tuberculosis and HIV, shall supersede this section.

WAC [246-100-211](#)

Special disease – Tuberculosis.

- (1) Health care providers diagnosing or caring for a person with tuberculosis, whether pulmonary or nonpulmonary, shall:
- (a) Report the case to the local health officer or local health department in accordance with the provisions of this chapter, and
 - (b) Report patient status to the local health officer every three months or as requested.
- (2) The local health officer or local health department shall:
- (a) Have primary responsibility for control of tuberculosis within the designated jurisdiction;
 - (b) Maintain a tuberculosis control program including:
 - (i) Prophylaxis,
 - (ii) Treatment,
 - (iii) Surveillance,
 - (iv) Case finding,
 - (v) Contact tracing, and
 - (vi) Other aspects of epidemiologic investigation;
 - (c) Maintain a tuberculosis register of all persons with tuberculosis, whether new or recurrent, within the local jurisdiction including information about:
 - (i) Identification of patient,
 - (ii) Clinical condition,
 - (iii) Epidemiology of disease,
 - (iv) Frequency of examinations;
 - (d) Impose isolation of a person with tuberculosis in an infectious stage if that person does not observe precautions to prevent the spread of the infection;
 - (e) Designate the place of isolation when imposed;
 - (f) Release the person from isolation when appropriate;
 - (g) Maintain and provide outpatient tuberculosis diagnostic and treatment services as necessary, including public health nursing services and physician consultation; and
 - (h) Submit reports of all cases to the department in accordance with the provisions of this chapter.
- (3) When a person with tuberculosis requires hospitalization,
- (a) Hospital admission shall occur in accordance with procedures arranged by the local health officer and

the medical director or administrator of the hospital, and

(b) The principal health care provider shall:

(i) Maintain responsibility for deciding date of discharge, and

(ii) Notify the local health officer of intended discharge in order to assure appropriate outpatient arrangements.

Notifiable conditions.

WAC [246-101-101](#)

Notifiable Conditions and the health care provider.

This section describes the conditions that Washington's health care providers must notify public health authorities of on a statewide basis. The board finds that the conditions in Table HC-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington.

(1) Principal health care providers shall notify public health authorities of the conditions identified in Table HC-1 of this section as individual case reports following the requirements in WAC [246-101-105](#), [246-101-110](#), [246-101-115](#), and [246-101-120](#).

(2) Other health care providers in attendance, other than the principal health care provider, shall notify public health authorities of the conditions identified in Table HC-1 of this section unless the condition notification has already been made.

(3) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.

WAC [246-101-105](#)

Duties of the health care provider.

Health care providers shall:

(1) Notify the local health department where the patient resides, or, in the event that patient residence cannot be determined, the local health department in which the health care providers practice, regarding:

(a) Cases or suspected cases of notifiable conditions specified as notifiable to local health departments in Table HC-1 of WAC [246-101-101](#);

(b) Cases of conditions designated as notifiable by the local health officer within that health officer's jurisdiction;

(c) Outbreaks or suspected outbreaks of disease including, but not limited to, suspected or confirmed outbreaks of varicella, influenza, viral meningitis, health care-associated infection suspected due to contaminated food products or devices, or environmentally related disease;

(d) Known barriers which might impede or prevent compliance with orders for infection control or quarantine; and

(e) Name, address, and other pertinent information for any case, suspected case or carrier refusing to comply with prescribed infection control measures.

(2) Notify the department of conditions designated as notifiable to the local health department when:

(a) A local health department is closed or representatives of the local health department are unavailable at the time a case or suspected case of an immediately notifiable condition occurs;

(b) A local health department is closed or representatives of the local health department are unavailable at the time an outbreak or suspected outbreak of communicable disease occurs.

- (3) Notify the department of pesticide poisoning that is fatal, causes hospitalization or occurs in a cluster.
- (4) Notify the department regarding cases of notifiable conditions specified as notifiable to the department in Table HC-1 of WAC [246-101-101](#).
- (5) Assure that positive preliminary test results and positive final test results for notifiable conditions of specimens referred to laboratories outside of Washington for testing are correctly notified to the local health department of the patient's residence or the department as specified in Table Lab-1 of WAC [246-101-201](#). This requirement can be satisfied by:
 - (a) Arranging for the referral laboratory to notify either the local health department, the department, or both; or
 - (b) Forwarding the notification of the test result from the referral laboratory to the local health department, the department, or both.
- (6) Cooperate with public health authorities during investigation of:
 - (a) Circumstances of a case or suspected case of a notifiable condition or other communicable disease; and
 - (b) An outbreak or suspected outbreak of disease.
- (7) Provide adequate and understandable instruction in disease control measures to each patient who has been diagnosed with a case of a communicable disease, and to contacts who may have been exposed to the disease.
- (8) Maintain responsibility for deciding date of discharge for hospitalized tuberculosis patients.
- (9) Notify the local health officer of intended discharge of tuberculosis patients in order to assure appropriate outpatient arrangements are arranged.
- (10) By July 1, 2011, when ordering a laboratory test for a notifiable condition as identified in Table HC-1 of WAC [246-101-101](#), providers must provide the laboratory with the following information for each test order:
 - (a) Patient name;
 - (b) Patient address including zip code;
 - (c) Patient date of birth;
 - (d) Patient sex;
 - (e) Name of the principal health care provider;
 - (f) Telephone number of the principal health care provider;
 - (g) Type of test requested;
 - (h) Type of specimen;
 - (i) Date of ordering specimen collection.

WAC [246-101-201](#)

Notifiable Conditions and laboratories.

This section describes the conditions about which Washington's laboratories must notify public health authorities of on a statewide basis. The board finds that the conditions in Table Lab-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions in Washington. The board also finds that submission of specimens for many of these conditions will further prevent the spread of disease.

- (1) Laboratory directors shall notify public health authorities of positive preliminary test results and positive final test results of the conditions identified in Table Lab-1 of this section as individual case reports and provide specimen submissions following the requirements in WAC [246-101-205](#), [246-101-210](#), [246-101-215](#), [246-101-220](#), [246-101-225](#), and [246-101-230](#).

(2) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.

WAC [246-101-301](#)

Notifiable Conditions and the health care facilities.

This section describes the conditions that Washington's health care facilities must notify public health authorities of on a statewide basis. The board finds that the conditions in Table HF-1 of this section are notifiable for the prevention and control of communicable and noninfectious diseases and conditions.

(1) Health care facilities shall notify public health authorities of cases that occur in their facilities of the conditions identified in Table HF-1 of this section following the requirements in WAC [246-101-305](#), [246-101-310](#), [246-101-315](#), and [246-101-320](#). This is not intended to require health care facilities to confirm the absence of conditions listed in Table HF-1 in facility patients.

(2) Health care facilities may choose to assume the notification for their health care providers for conditions designated in Table HF-1 of this section.

(3) Health care facilities may not assume the reporting requirements of laboratories that are components of the health care facility.

(4) Local health officers may require additional conditions to be notifiable within the local health officer's jurisdiction.

Contagious Disease – School Districts and Childcare Centers.

WAC [246-110-010](#)

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Childcare center" means any facility or center licensed by the department of early learning as described in chapter [43.215](#) RCW that regularly provides care for a group of children for periods of less than twenty-four hours per day.

(2) "Contact" means a person exposed to a contagious person or animal, or a contaminated source which might provide an opportunity to acquire the infection.

(3) "Contagious disease" means an illness caused by an infectious agent of public health concern which can be transmitted from one person, animal, or object to another person by direct or indirect means including transmission through an intermediate host or vector, food, water, or air. Contagious diseases include, but are not limited to:

(a) Bacterial Meningitis

(i) Haemophilus influenzae invasive disease (excluding Otitis media)

(ii) Meningococcal

(b) Diarrheal diseases due to or suspected to be caused by an infectious agent

(i) Cryptosporidiosis

(ii) Giardiasis

(iii) Hepatitis A

(iv) Salmonellosis

(v) Shigellosis

(vi) Shiga toxin-producing Escherichia coli (STEC)

(c) Diseases spread through the air - Tuberculosis

(d) Vaccine preventable diseases

(i) Chickenpox (Varicella)

- (ii) Diphtheria
- (iii) German measles (Rubella)
- (iv) Measles (Rubeola)
- (v) Mumps
- (vi) Whooping cough (Pertussis)
- (4) "Contaminated" means containing or having contact with infectious agents that pose an immediate threat to present or future public health.
- (5) "Exposed" means such association with a person or animal in the infectious stage of a disease, or with a contaminated source, which provides the opportunity to acquire the infection.
- (6) "Infectious agent" means an organism that is capable of producing infection or infectious disease.
- (7) "Outbreak" means the occurrence of cases of a disease or condition in any area over a given period of time in excess of the expected number of cases as determined by the local health officer.
- (8) "School" means each building, facility, and location at or within which any or all portions of a preschool, kindergarten, and grades one through twelve program of education and related activities are conducted for two or more students or children by or on behalf of any public school district and by or on behalf of any private school or private institution subject to approval by the state board of education.
- (9) "Susceptible" means a person who has no immunity to an infectious agent.

WAC [246-170-002](#)

Findings and purpose.

(1) The board of health finds that:

(a) Pulmonary tuberculosis is a life-threatening airborne disease that can be casually transmitted without significant interaction with an infectious person. Tuberculosis has reemerged as an epidemic disease nationally, and though Washington state is not in an epidemic yet, the increasing number of cases in Washington state each year clearly demonstrate that absent timely and effective public health intervention in individual cases, the residents of the state of Washington are at risk of being infected by tuberculosis.

(b) In order to limit the spread of tuberculosis, it is essential that individuals who have the disease are diagnosed and treated before they infect others. Diagnosis requires a variety of methodologies including skin tests, X rays, and laboratory analysis of sputum samples.

(c) A person with infectious tuberculosis who does not voluntarily submit to appropriate testing, treatment, or infection control methods poses an unreasonable risk of spreading the disease to those who come into the infectious person's proximity.

(d) Although the recommended course of treatment for tuberculosis varies somewhat from one individual to another, at a minimum, effective treatment requires a long-term regimen of multiple drug therapy. Some drugs are effective with some individuals but not others. The development of the appropriate course of treatment for any one individual may require trying different combinations of drugs and repeated drug susceptibility testing. The course of treatment may require as long as several years to complete.

(e) A person who begins a course of treatment for tuberculosis and fails to follow the recommended course through to completion is highly likely to relapse at some point into infectious tuberculosis. The person will most likely then be infected with what is known as multiple drug resistant tuberculosis, which is more virulent, more difficult to treat, and more likely to result in fatality. A person who is infectious with multiple drug resistant tuberculosis poses a significant risk of transmitting multiple drug resistant tuberculosis to other persons, unless appropriate treatment and infection control methods are followed.

- (f) Multiple drug resistant tuberculosis is a significant element in the epidemic that is being encountered nation-wide, and effective public health interventions are necessary to prevent that epidemic from developing in or spreading to Washington state.
- (2) The following rules are adopted for the purpose of establishing standards necessary to protect the public health by:
- (a) Assuring the diagnosis, treatment, and prevention of tuberculosis; and
 - (b) Assuring that the highest priority is given to providing appropriate individualized preventive and curative treatment in the least restrictive setting.

Tuberculosis – Prevention, Treatment, and Control.

WAC 246-170-011

Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter.

"Case management" means a comprehensive, ongoing identification of needs, including the need for any medical, social, educational, or other support services; the development and implementation of a detailed plan of services and related activities; use of community linkages; and advocacy for the client performed in a prescribed, accountable manner.

"Confirmed" or "confirmed case" means an individual who has a positive bacteriologic culture for *Mycobacterium tuberculosis* complex or a suspected case that shows response to an appropriate course of treatment.

"Department" means the department of health.

"Detention" or "detain" means the act of restricting an individual's movement by confining the person.

"Directly observed therapy (DOT)" and "directly observed preventive therapy (DOPT)" mean providing oral medications to patients and observing ingestion of medications by patients.

"Infected" means an individual who has tubercle bacilli as identified by a positive tuberculin skin test, but is not capable of transmitting the organism to another person.

"Infectious" means the stage of disease in which an individual transmits viable tuberculosis organisms into the air.

"Inpatient" means health care furnished to an individual who has been admitted to a hospital.

"Outpatient" means health care furnished to an individual who is not an inpatient.

"Personal protective equipment" means respirators and other equipment as required by the department of labor and industries.

"Prevention" means the interventions that interrupt the spread of tuberculosis, either within an individual, within the population, or both.

"Preventive therapy" means either treatment to prevent infection in an uninfected person or treatment to prevent disease in an infected person.

"Primary health care provider" means the person who assumes the day-to-day medical care of a tuberculosis patient.

"Suspected case" means an individual with signs or symptoms suggestive of tuberculosis disease prior to confirmation.

"Treatment" means a course of long-term multiple drug or other appropriate therapy prescribed for an individual with suspected or confirmed disease in accordance with accepted medical practice and current applicable national and state guidelines, and may include preventive therapy.

"Tuberculin skin test" means the introduction of purified protein derivative (PPD) by the Mantoux method.

"Tuberculosis community health worker" means an unlicensed person trained to perform tuberculin skin testing, directly observed therapy, and directly observed preventive therapy and working pursuant to chapter [70.28](#) RCW as part of a program established by a state or local health officer to control tuberculosis.

WAC 246-170-021

Responsibility of local health officers.

Each county, city-county and district health officer is responsible for the control of tuberculosis within a jurisdiction. Each health officer shall act as or shall designate a physician to act as tuberculosis control officer. This individual shall coordinate all aspects of the prevention, treatment, and control program.

WAC 246-170-031

Local health department responsibilities.

(1) Each local health department shall assure the provision of a comprehensive program for the prevention, treatment, and control of tuberculosis. Services shall include:

- (a) Prevention and screening, with emphasis on screening of high risk populations;
- (b) Diagnosis and monitoring, including laboratory and radiology;
- (c) Individualized treatment planning consistent with American Thoracic Society/Centers for Disease Control and Prevention statements based on the least restrictive measures necessary to assure appropriate treatment; and
- (d) Case management.

(2) In the absence of third party reimbursement, the local health department shall assure the provision of inpatient or outpatient care, including DOT/DOPT and case management.

(3) Each local health department shall maintain a register of all diagnosed or suspected cases of tuberculosis. In addition, each local health department shall also maintain a register of individuals to whom that health department is providing preventive therapy. Quarterly status reports on suspected and diagnosed cases shall be furnished to the department of health tuberculosis control program.

(4) A physician knowledgeable in the diagnosis and treatment of tuberculosis approved by the department shall be available to provide review of diagnoses, plans of management and, if appropriate, discharge from inpatient facilities.

(5) Sufficient nursing, clerical, and other appropriate personnel shall be provided to furnish supervision of preventive and outpatient treatment, surveillance, suspect evaluation, epidemiologic investigation, and contact workup.

WAC 246-170-035

Tuberculin skin testing and medication administration testing.

The department shall make available a course to be used by the state tuberculosis control program or local health departments to train tuberculosis community health workers.

This course shall include, but not be limited to:

- (1) Tuberculosis infection and disease, including prevention, transmission, pathogenesis, diagnosis and treatment;
- (2) The administration, reading, and interpretation of the Mantoux tuberculin skin test;
- (3) The performance of oral directly observed therapy and directly observed preventive therapy;
- (4) Adverse reactions to tuberculosis medications and how to monitor patients for adverse reactions;
- (5) Appropriate referral mechanisms for positive skin tests, adverse reactions, or other medical needs;

(6) Personal health and safety requirements including the use of personal protective equipment.

WAC 246-170-041

Inpatient services requirements.

(1) Inpatient services to infectious or suspected cases shall be provided in hospitals or hospital units of correctional facilities. These facilities shall meet infection control program requirements pursuant to WAC 246-318-035, and shall provide:

- (a) A single-patient room consistent with the guidelines set forth in the *1994 CDC Guidelines For Preventing the Transmission of Tuberculosis in Health Care Facilities*, or as hereafter amended. Copies of these guidelines are available from the Washington state department of health, TB control program;
- (b) Medical, nursing, laboratory, radiology, pharmacy, patient education, and social services;
- (c) Discharge conferences involving at least the current primary provider, a local health department representative, and transferring and receiving facility representatives.

(2) Suspected and infectious cases may be housed and treated in other settings not meeting the requirements of this section only as approved by the local health officer.

WAC 246-170-051

Procedures for involuntary testing, treatment, and detention.

(1) A local health officer shall make reasonable efforts to obtain voluntary compliance with requests for examination, testing, and treatment prior to initiating the procedures for involuntary detention.

(2) If the local health officer has reason to believe that:

- (a) A person is a suspected case, and that the person has failed to comply with a documented request from a health care practitioner or the local health officer to submit to examination and testing;
- (b) A person with confirmed tuberculosis is failing to comply with an individual treatment plan approved by the local health officer;
- (c) A person who is either a suspected or confirmed case and is failing to comply with infection control directives issued by the local health officer; or
- (d) A person is a suspected or confirmed case of tuberculosis based upon generally accepted standards of medical and public health science. A local health officer shall investigate and evaluate the factual basis supporting his or her "reason to believe";

then the health officer may detain the person, cause the person to be detained by written order, or petition the superior court *ex parte* for an order to take the person into emergency detention for testing or treatment, or both. The period of detention shall not exceed seventy-two hours, excluding weekends and holidays.

(3) At the time of detention the person detained shall be given the following written notice:

NOTICE: You have the right to a superior court hearing within seventy-two hours of detention, excluding holidays and weekends. You have the right to legal counsel. If you are unable to afford legal counsel, then counsel will be appointed for you at government expense and you should request the appointment of counsel at this time. If you currently have legal counsel, then you have an opportunity to contact that counsel for assistance.

You have a right to contest the facts alleged against you, to cross-examine witnesses, and to present evidence and witnesses on your behalf.

You have a right to appeal any decision made by the court.

You may be given appropriate TB medications only on your informed consent, or pursuant to a court order.

(4) If a person is involuntarily detained under this section, within one judicial day of initial detention, the local health officer shall file with the superior court in the county of detention a petition for detention. A petition filed under this section shall specify:

(a) The basis for the local health officer's belief that the respondent is either a suspected or confirmed case; including the name, address and phone numbers of whom the health officer expects to testify in support of the petition for detention and identification of any and all medical tests and records relied upon by the local health officer;

(b) The specific actions taken by the local health officer to obtain voluntary compliance by the respondent with recommended examination and testing or treatment, as the case may be;

(c) The nature and duration of further detention or other court-ordered action that the local health officer believes is necessary in order to assure that the respondent is appropriately tested or treated;

(d) The basis for believing that further detention or other court-ordered action is necessary to protect the public health; and

(e) Other information the local health officer believes is pertinent to the proper resolution of the petition.

(5) Service on respondent. The health officer shall serve a copy of the petition on the individual named therein at the time of the detention. If the person informs the health officer that he or she is represented by legal counsel, service on such counsel shall be made by delivering a copy of the petition to the attorney's office no later than the time of filing the petition with the superior court.

WAC [246-170-055](#)

Due process proceedings.

(1) A hearing on the petition for detention filed under WAC [246-170-051](#) shall be conducted in superior court within seventy-two hours after initial detention, excluding weekends and holidays. The local health officer shall have the burden of proving the allegations set forth in the petition by a preponderance of the evidence. The person named in the petition shall have the right to cross-examine witnesses, present evidence, and be represented by an attorney at any hearing held on the petition. If the person is indigent and requests appointment of legal counsel, legal counsel shall be appointed at public expense at least twenty-four hours prior to the superior court hearing.

(2) At the conclusion of the hearing, the court shall consider the evidence, the action taken by the health officer to secure voluntary compliance by the patient, and the purpose and intent of the public health laws, including this chapter, and may take one of the following actions:

(a) If the court finds that the respondent is a suspected case, the court may enter an order requiring that the person be subjected to further examination, testing, and treatment as specified in the court's order.

If the court finds that further detention of the respondent is necessary in order to assure that the examination, testing, and treatment occurs, or to protect the public health the court may order that the respondent be detained for an additional period not to exceed forty-five days. The results of testing conducted under this chapter shall be provided to the court and the person detained or his or her legal counsel as soon as they are available to the local health officer. The court may then conduct an additional hearing to determine whether the person is a confirmed case and, if so, whether further measures are necessary to protect the public health pursuant to (b) or (c) of this subsection.

(b) If the court finds that the person is a confirmed case, that further measures less restrictive than detention of the respondent are necessary to assure that appropriate treatment is implemented and that imposition of less restrictive measures will be sufficient to protect the public health, the court may enter an order setting forth such measures and ordering the respondent to comply with the measures.

(c) If the court finds that the person is a confirmed case, that further detention of the respondent is necessary to protect the public health, and that imposition of less restrictive measures will not be

sufficient to protect the public health, the court may order that the respondent be detained and treated for an additional period not to exceed forty-five days.

(d) If the court finds that there is insufficient evidence to support the petition for detention, then the court shall immediately release the person detained.

(3) A person detained under this chapter may be released prior to the expiration of the court-ordered detention if the health officer or the court finds that less restrictive measures are sufficient to protect the public health. The court may impose such conditions on the release of the person as the court finds are necessary to protect the public health. A person detained under this chapter may also petition the court for release based upon new evidence or a change in circumstances.

(4) The court may extend a period of court-ordered detention for additional periods not to exceed one hundred eighty days each following a hearing as described in [WAC 246-170-051](#) and this section, if the court finds that the requirements of subsection (2)(a), (b), or (c) of this section have been met and if the court finds that further detention is necessary to assure that appropriate treatment is implemented, and that imposition of less restrictive measures are not sufficient to protect the public health. As an alternative to extending the period of detention, if the court finds after hearing that further measures less restrictive than detention are necessary to assure that appropriate treatment is continued, and that imposition of less restrictive measures will be sufficient to protect the public health, the court may enter an order setting forth the measures and ordering the respondent to comply.

(5) In the event that a person has been released from detention prior to completion of the prescribed course of treatment and fails to comply with the prescribed course of treatment, the health officer where that individual is found may detain that person, and any court having jurisdiction of the person may order the person detained for an additional period or periods, not to exceed one hundred eighty days each, as the court finds necessary to protect the public health.

(6) If a person has been detained in a county other than the county in which the court that originally ordered the detention is located, venue of the proceedings may remain in the original county, or may be transferred to the county of detention. Change in venue may be sought either by the local health officer in the original county or in the county of detention, or by the person detained. Except as otherwise agreed between the original health officer and the health officer in the county of detention, the original health officer retains jurisdiction over the detained person, including financial responsibility for costs incurred in implementing and continuing the detention.

(7) Court orders entered under this chapter shall be entered only after a hearing at which the respondent is accorded the same rights as at the initial hearing on the petition for detention.

(8)(a) When a court order for detention is issued, the transporting law enforcement agency and the receiving facility shall be informed of the infectious TB status of the person for disease control and the protection of the health of the staff, other offenders and the public. Such information shall be made available prior to the transport.

(b) Whenever disclosure is made pursuant to this subsection, it shall be accompanied by a statement in writing which includes the following or substantially similar language: "This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it except as authorized by state law."

(c) Transporting agencies and/or receiving facilities shall establish and implement policies and procedures that maintain confidentiality related to the detained person's medical information as defined in this subsection and state law.

Hospital Licensing Regulations.

WAC [246-320-156](#)

Management of human resources.

This section ensures that hospitals provide competent staff consistent with scope of services.

Hospitals must:

- (1) Establish, review, and update written job descriptions for each job classification;
- (2) Conduct periodic staff performance reviews;
- (3) Assure qualified staff available to operate each department including a process for competency, skill assessment and development;
- (4) Assure supervision of staff;
- (5) Document verification of staff licensure, certification, or registration;
- (6) Complete tuberculosis screening for new and current employees consistent with the *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities, 2005. Morbidity Mortality Weekly Report (MMWR) Volume 54, December 30, 2005;*
- (7) Orient staff to their assigned work environment;
- (8) Give infection control information to staff upon hire and annually which includes:
 - (a) Education on general infection control according to chapter [296-823](#) WAC bloodborne pathogens exposure control;
 - (b) Education specific to infection control for multidrug-resistant organisms; and
 - (c) General and specific infection control measures related to the patient care areas where staff work;
- (9) Establish and implement an education plan that verifies or arranges for the training of staff on prevention, transmission, and treatment of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) consistent with RCW [70.24.310](#).

Private Psychiatric and Alcoholism Hospitals.

WAC [246-322-050](#)

Staff.

The licensee shall:

- (1) Employ sufficient, qualified staff to:
 - (a) Provide adequate patient services;
 - (b) Maintain the hospital free of safety hazards; and
 - (c) Implement fire and disaster plans;
- (2) Develop and maintain a written job description for the administrator and each staff position;
- (3) Maintain evidence of appropriate qualifications and current credentials prior to hiring, or granting or renewing clinical privileges or association of any health care professional;
- (4) Verify work references prior to hiring staff;
- (5) Assure all patient-care staff including those transporting patients and supervising patient activities, except licensed staff whose professional training exceeds first-responder training, have within thirty days of employment:
 - (a) Current cardiopulmonary resuscitation cards from instructors certified by the American Red Cross, American Heart Association, United States Bureau of Mines, or Washington state department of labor and industries; and
 - (b) Current first-aid cards from instructors certified as in (a) of this subsection;
- (6) Provide and document orientation and appropriate training for all staff, including:
 - (a) Organization of the hospital;
 - (b) Physical layout of hospital, including buildings, departments, exits, and services;
 - (c) Fire and disaster plans, including monthly drills;
 - (d) Infection control;
 - (e) Specific duties and responsibilities;

- (f) Policies, procedures, and equipment necessary to perform duties;
- (g) Patient rights according to chapters [71.05](#) and [71.34](#) RCW and patient abuse;
- (h) Managing patient behavior; and
- (i) Appropriate training for expected duties;
- (7) Make available an ongoing, documented, in-service education program, including but not limited to:
 - (a) For each staff person, training to maintain and update competencies needed to perform assigned duties and responsibilities; and
 - (b) For patient care staff, in addition to (a) of this subsection, the following training:
 - (i) Methods of patient care;
 - (ii) Using the least restrictive alternatives;
 - (iii) Managing assaultive and self-destructive behavior;
 - (iv) Patient rights pursuant to chapters [71.05](#) and [71.34](#) RCW;
 - (v) Special needs of the patient population, such as children, minorities, elderly, and individuals with disabilities;
 - (vi) Cardiopulmonary resuscitation; and
 - (vii) First-aid training;
- (8) When volunteer services are used within the hospital:
 - (a) Designate a qualified employee to be responsible for volunteer services;
 - (b) Provide and document orientation and training according to subsections (6) and (7) of this section for each volunteer; and
 - (c) Provide supervision and periodic written evaluations of each volunteer working directly with patients;
- (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital:
 - (a) A tuberculin skin test by the Mantoux method, unless the staff person:
 - (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours;
 - (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or
 - (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health;
 - (b) A second test one to three weeks after a negative Mantoux skin test for staff thirty-five years of age or older; and
 - (c) A chest X ray within seven days of any positive Mantoux skin test;
- (10) Report positive chest X rays to the appropriate public health authority, and follow precautions ordered by a physician or public health authority;
- (11) Restrict a staff person's contact with patients when the staff person has a known communicable disease in the infectious stage which is likely to be spread in the hospital setting or by casual contact; and
- (12) Maintain a record on the hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to:
 - (a) An employment application;
 - (b) Verification of required education, training and credentials;
 - (c) Documentation of contacting work references as required by subsection (4) of this section;
 - (d) Criminal history disclosure and background checks as required in WAC [246-322-030](#);
 - (e) Verification of current cardiopulmonary resuscitation, first-aid and HIV/AIDS training;

- (f) Tuberculin test results, reports of X-ray findings, exceptions, physician or public health official orders, and waivers; and
- (g) Annual performance evaluations.

WAC 246-322-190

Provisions for patients with tuberculosis.

A licensee providing inpatient services for mentally ill patients with suspected or known infectious tuberculosis shall:

- (1) Design patient rooms with:
 - (a) Ventilation to maintain a negative pressure condition in each patient room relative to adjacent spaces, except bath and toilet areas, with:
 - (i) Air movement or exhaust from the patient room to the out-of-doors with the exhaust grille located over the head of the bed;
 - (ii) Exhaust at the rate of six air changes per hour;
 - (iii) Make-up or supply air from adjacent ventilated spaces for four or less air changes per hour, and tempered outside air for two or more air changes per hour; and
 - (iv) Ultraviolet generator irradiation as follows:
 - (A) Use of ultraviolet fluorescent fixtures with lamps emitting wave length of 253.7 nanometers;
 - (B) The average reflected irradiance less than 0.2 microwatts per square centimeter in the room at the five foot level;
 - (C) Wall-mount type of fixture installed over the head of the bed, as close to the ceiling as possible to irradiate the area of the exhaust grille and the ceiling; and
 - (D) Lamps changed as recommended by the manufacturer; and
 - (b) An adjoining bathroom and toilet room with bedpan washer; and
- (2) Provide discharge information to the health department of the patient's county of residence.

Private Alcohol and Chemical Dependency Hospitals.

WAC 246-324-050

Staff.

The licensee shall:

- (1) Employ sufficient, qualified staff to:
 - (a) Provide adequate patient services;
 - (b) Maintain the hospital free of safety hazards; and
 - (c) Implement fire and disaster plans;
- (2) Develop and maintain a written job description for the administrator and each staff position;
- (3) Maintain evidence of appropriate qualifications and current credentials prior to hiring, or granting or renewing clinical privileges or association of any health care professional;
- (4) Verify work references prior to hiring staff;
- (5) Assure all patient-care staff including those transporting patients and supervising patient activities, except licensed staff whose professional training exceeds first-responder training, have within thirty days of employment:
 - (a) Current cardiopulmonary resuscitation cards from instructors certified by the American Red Cross, American Heart Association, United States Bureau of Mines, or Washington state department of labor and industries; and
 - (b) Current first-aid cards from instructors certified as in (a) of this subsection;

- (6) Provide and document orientation and appropriate training for all staff, including:
 - (a) Organization of the hospital;
 - (b) Physical layout of hospital, including buildings, departments, exits, and services;
 - (c) Fire and disaster plans, including monthly drills;
 - (d) Infection control;
 - (e) Specific duties and responsibilities;
 - (f) Policies, procedures, and equipment necessary to perform duties;
 - (g) Patient rights according to chapters [71.05](#) and [71.34](#) RCW and patient abuse;
 - (h) Managing patient behavior; and
 - (i) Appropriate training for expected duties;
- (7) Make available an ongoing, documented, in-service education program, including but not limited to:
 - (a) For each staff person, training to maintain and update competencies needed to perform assigned duties and responsibilities; and
 - (b) For patient care staff, in addition to (a) of this subsection, the following training:
 - (i) Methods of patient care;
 - (ii) Using the least restrictive alternatives;
 - (iii) Managing assaultive and self-destructive behavior;
 - (iv) Patient rights pursuant to chapters [71.05](#) and [71.34](#) RCW;
 - (v) Special needs of the patient population, such as children, minorities, elderly, and individuals with disabilities;
 - (vi) Cardiopulmonary resuscitation; and
 - (vii) First-aid training;
- (8) When volunteer services are used within the hospital:
 - (a) Designate a qualified employee to be responsible for volunteer services;
 - (b) Provide and document orientation and training according to subsections (6) and (7) of this section for each volunteer; and
 - (c) Provide supervision and periodic written evaluations of each volunteer working directly with patients;
- (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital:
 - (a) A tuberculin skin test by the Mantoux method, unless the staff person:
 - (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours;
 - (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or
 - (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health;
 - (b) A second test one to three weeks after a negative Mantoux skin test for staff thirty-five years of age or older; and
 - (c) A chest X ray within seven days of any positive Mantoux skin test;
- (10) Report positive chest X rays to the appropriate public health authority, and follow precautions ordered by a physician or public health authority;
- (11) Restrict a staff person's contact with patients when the staff person has a known communicable disease in the infectious stage which is likely to be spread in the hospital setting or by casual contact; and
- (12) Maintain a record on the hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to:

- (a) An employment application;
- (b) Verification of required education, training and credentials;
- (c) Documentation of contacting work references as required by subsection (4) of this section;
- (d) Criminal history disclosure and background checks as required in WAC [246-322-030](#);
- (e) Verification of current cardiopulmonary resuscitation, first-aid and HIV/AIDS training;
- (f) Tuberculin test results, reports of X-ray findings, exceptions, physician or public health official orders, and waivers; and
- (g) Annual performance evaluations.

WAC [246-324-190](#)

Provisions for patients with tuberculosis.

A licensee providing inpatient services for mentally ill patients with suspected or known infectious tuberculosis shall:

- (1) Design patient rooms with:
 - (a) Ventilation to maintain a negative pressure condition in each patient room relative to adjacent spaces, except bath and toilet areas, with:
 - (i) Air movement or exhaust from the patient room to the out-of-doors with the exhaust grille located over the head of the bed;
 - (ii) Exhaust at the rate of six air changes per hour;
 - (iii) Make-up or supply air from adjacent ventilated spaces for four or less air changes per hour, and tempered outside air for two or more air changes per hour; and
 - (iv) Ultraviolet generator irradiation as follows:
 - (A) Use of ultraviolet fluorescent fixtures with lamps emitting wave length of 253.7 nanometers;
 - (B) The average reflected irradiance less than 0.2 microwatts per square centimeter in the room at the five foot level;
 - (C) Wall-mount type of fixture installed over the head of the bed, as close to the ceiling as possible to irradiate the area of the exhaust grille and the ceiling; and
 - (D) Lamps changed as recommended by the manufacturer; and
 - (b) An adjoining bathroom and toilet room with bedpan washer; and
- (2) Provide discharge information to the health department of the patient's county of residence.

Childbirth Centers.

WAC [246-329-065](#)

New construction—Major alterations.

The purpose of this section is to provide minimum standards for a safe and efficient patient care environment consistent with other rules. The rules are intended to allow flexibility in achieving desired outcomes and enable birth centers to respond to changes in technologies and health care innovations.

- (1) When a licensee or applicant is contemplating new construction or major alteration, the licensee or applicant shall:
 - (a) Under chapters [70.40](#) RCW and [246-329](#) WAC, submit an application and construction documents to the department's construction review services program for all new construction and major alterations, as defined in WAC [246-329-010](#). In addition to the application and construction documents, the construction review services program may require documentation of approval from local zoning commissions, fire departments, and building departments, if applicable;
 - (b) Respond in writing when the department requests additional or corrected construction documents;

- (c) Not begin construction until the construction documents are approved by the local jurisdictions and same local jurisdictions have issued any required permits;
- (d) Complete construction consistent with the final "department approved" documents;
- (e) Notify the department in writing when construction is completed; and
- (f) Submit to the department a copy of the local jurisdictions' certificate of occupancy.

(2) A childbirth center applicant or licensee must, through its design, construction and necessary permits demonstrate compliance with the following codes and local jurisdiction standards:

- (a) The state building code as adopted by the state building code council.
- (b) *Accepted Procedure and Practice in Cross-contamination Control, Pacific Northwest Edition, 9th Edition, American Waterworks Association*; and
- (c) If planning on caring for patients with mycobacterium tuberculosis, *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities, 1994. Morbidity and Mortality Weekly Report (MMWR), Volume 43, October 28, 1994.*

WAC 246-329-110

Personnel policy and procedures and records.

The purpose of this section is to ensure the birth center provides direction and standards in the employment, contracting and recording of personnel procedures.

(1) A childbirth center applicant or licensee must establish and implement policy and procedures which include, but are not limited to:

- (a) For those birth centers operated by an employer as defined by RCW 49.60.040(3), employment criteria consistent with chapter 49.60 RCW;
- (b) Job descriptions for employees, contractor agreements, volunteer responsibility statements and agreements with students commensurate with responsibilities and consent with health care professional credentialing and scope of practice as defined in relevant practice acts and associated rules;
- (c) Verification of clinical staff credentials;
- (d) Orientation to current agency policies and procedures and verification of skills or training for all clinical staff;
- (e) Current neonatal and adult cardiopulmonary resuscitation training consistent with agency policies and procedures and community standards for all clinical staff;
- (f) Infection control practices for clinical staff including communicable disease testing, immunization, vaccination and universal precautions or equivalent method of preventing the transmission of infection according to current local health authorities and shall include the availability of equipment necessary to implement plans of care and infection control policies and procedures;
- (i) Birth centers must establish and implement a TB screening program for personnel;
- (ii) Birth centers must provide or offer to employees Hepatitis B vaccination according to WAC 296-62-08001; and
- (iii) Birth centers must assure that all contractors have received or been offered Hepatitis B vaccination according to WAC 296-62-08001;
- (g) Verification of appropriate education and training of all personnel, contractors, student and volunteers on the prevention, transmission, and treatment of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) consistent with RCW 70.24.310;
- (h) Performance evaluations of all personnel, including evaluations of contractor and student agreements to be conducted per birth center's policy and procedure; and
- (i) Washington state patrol criminal background inquiries and disclosure statements under RCW 43.43.830 through 43.43.845 for the administrator, owner, director of services and personnel, contractors, volunteers, students, and any other individual associated with the licensee who has direct

contact with children under sixteen years of age, people with developmental disabilities or vulnerable adults.

(2) Each employee, contractor, student and volunteer shall have a current record maintained by the birth center which contains, but is not limited to, the following information:

(a) Documentation of the items stated above in subsection (1)(b) through (e) and (g) through (i) of this section.

(b) Evidence of communicable disease testing as required by local health authorities and per birth center policy and procedures and shall include, at a minimum, documented evidence of tuberculin (TB) screening as required in WAC 246-329-110 (1)(f) and documented evidence of Hepatitis B vaccination being provided or offered according to WAC [296-62-08001](#).

Ambulatory Surgical Facilities.

WAC [246-330-140](#)

Management of human resources.

This section ensures that ambulatory surgical facilities provide competent staff consistent with scope of services.

Ambulatory surgical facilities must:

(1) Create and periodically review job descriptions for all staff;

(2) Supervise staff performance to assure competency;

(3) Verify and document licensure, certification, or registration of staff;

(4) Complete tuberculosis screening for new and current employees consistent with the *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Facilities, 2005. Morbidity Mortality Weekly Report (MMWR) Volume 54, December 30, 2005*;

(5) Provide infection control information to staff upon hire and annually which includes:

(a) Education on general infection control according to chapter [296-823](#) WAC blood borne pathogens exposure control; and

(b) General and specific infection control measures related to patient care.

(6) Establish and implement an education plan that verifies staff training on prevention, transmission, and treatment of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) consistent with RCW [70.24.310](#).

In-Home Services Agencies.

WAC [246-335-190](#)

Construction and design codes.

A hospice care center applicant must, through its design, construction and necessary permits demonstrate compliance with the following codes and local jurisdiction standards:

(1) As adopted by the state building code council, and the *Uniform Building Code Standards*, as published by the International Conference of Building Officials as amended and adopted by the Washington state building code council and published as chapter [51-40](#) WAC;

(2) *The Uniform Mechanical Code*, (as published by the International Conference of Building Officials and the International Association of Plumbing and Mechanical Officials) as amended and adopted by the Washington state building code council and published as chapter [51-42](#) WAC;

- (3) *Fire Code and Uniform Fire Code Standards*, as published by the International Conference of Building Officials and the Western Fire Chiefs Association as amended and adopted by the Washington state building code council and published as chapters [51-44](#) and [51-45](#) WAC;
- (4) *Plumbing Code and Uniform Plumbing Code Standards*, as published by the International Association of Plumbing and Mechanical Officials, as amended and adopted by the Washington state building code council and published as chapters [51-46](#) and [51-47](#) WAC;
- (5) *State Ventilation and Indoor Air Quality Code*, as adopted by the Washington state building code council and filed as chapter [51-13](#) WAC;
- (6) *The Washington State Energy Code*, as amended and adopted by the Washington state building code council and filed as chapter [51-13](#) WAC;
- (7) Electric Code of the National Fire Protection Association (NFPA-70) as adopted by the Washington state department of labor and industries including chapter [296-46A](#) WAC;
- (8) *Accepted Procedure and Practice in Cross-contamination Control*, Pacific Northwest Edition, 9th Edition, American Water Works Association;
- (9) If planning on caring for patients with mycobacterium tuberculosis, *Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Facilities*, 1994. Morbidity and Mortality Weekly Report (MMWR), Volume 43, October 28, 1994; and
- (10) *National Fire Protection Association Standards 99*, 1999 Edition.

Residential Treatment Facility.

WAC [246-337-050](#)

Management of human resources.

The licensee must ensure residents receive health care by adequate numbers of staff authorized and competent to carry out assigned responsibilities, including:

- (1) A sufficient number of personnel must be present on a twenty-four hour per day basis to meet the health care needs of the residents served; managing emergency situations; crisis intervention, implementation of health care plans; and required monitoring activities.
- (2) Personnel trained, authorized and credentialed (where applicable) to carry out assigned job responsibilities consistent with scopes of practice, resident population characteristics and the resident's individual plan of care/treatment;
- (3) The presence of at least one individual trained in basic first aid and age appropriate cardiopulmonary resuscitation twenty-four hours per day.
- (4) Written documentation to verify credentials, training, and performance evaluations for each staff member including, but not limited to:
 - (a) Employment application/hire date;
 - (b) Verification of education, experience and training;
 - (c) Current job description;
 - (d) Criminal disclosure statement and results of a Washington state patrol background inquiry;
 - (e) HIV/AIDS training or verification;
 - (f) Current license/certification/registration (if applicable);
 - (g) Current basic first aid and age appropriate cardiopulmonary resuscitation training (if applicable);
 - (h) Current food and beverage service worker permit (if applicable);
 - (i) Current driver's license (if applicable);
 - (j) Tuberculosis screening (refer to WAC [246-337-060](#));
 - (k) Performance evaluation(s);

- (l) Staff using restraint and seclusion procedures must receive initial and ongoing education and training in the proper and safe use of seclusion and/or restraints;
 - (m) Initial orientation and ongoing training to address the safety and health care needs of the population served.
- (5) If independent contractors, consultants, students, volunteers and trainees are providing direct on-site residential care, the licensee must ensure their compliance with this section.

WAC [246-337-060](#)

Infection control.

The licensee must ensure each resident's care is provided in an environment that prevents the transmission of infections and communicable disease among residents, staff, and visitors including:

- (1) Implementing and maintaining an infection control program by assignment of responsibility for infection control and monitoring to a specified staff member.
- (2) Maintaining an infection control program that includes adoption and implementation of written policies and procedures for:
 - (a) Meeting the standards as outlined in the most recent edition of the department's *Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Curriculum Manual*, including:
 - (i) Hand hygiene;
 - (ii) Disinfection;
 - (iii) Standard/universal precautions;
 - (b) Residents with poor hygiene;
 - (c) Control of bloodborne pathogens in accordance with WISHA, chapter [296-823](#) WAC;
 - (d) Control of tuberculosis consistent with WISHA, department guidelines, and chapter [246-170](#) WAC;
 - (e) Exclusion of staff from work who have a communicable disease in an infectious stage; and
 - (f) Environmental management and housekeeping functions.
- (3) Ensuring that staff report notifiable conditions and cooperate with public health authorities to facilitate investigation of a case, suspected case, or outbreak of a notifiable condition, consistent with chapter [246-101](#) WAC.
- (4) Providing the equipment necessary to implement the RTF infection control policies and procedures.
- (5) Complying with chapter [246-100](#) WAC "Communicable and certain other diseases."

Medical Test Site Rules.

WAC [246-337-060](#)

Infection control.

The licensee must ensure each resident's care is provided in an environment that prevents the transmission of infections and communicable disease among residents, staff, and visitors including:

- (1) Implementing and maintaining an infection control program by assignment of responsibility for infection control and monitoring to a specified staff member.
- (2) Maintaining an infection control program that includes adoption and implementation of written policies and procedures for:
 - (a) Meeting the standards as outlined in the most recent edition of the department's *Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) Curriculum Manual*, including:
 - (i) Hand hygiene;
 - (ii) Disinfection;
 - (iii) Standard/universal precautions;

- (b) Residents with poor hygiene;
 - (c) Control of bloodborne pathogens in accordance with WISHA, chapter [296-823 WAC](#);
 - (d) Control of tuberculosis consistent with WISHA, department guidelines, and chapter [246-170 WAC](#);
 - (e) Exclusion of staff from work who have a communicable disease in an infectious stage; and
 - (f) Environmental management and housekeeping functions.
- (3) Ensuring that staff report notifiable conditions and cooperate with public health authorities to facilitate investigation of a case, suspected case, or outbreak of a notifiable condition, consistent with chapter [246-101 WAC](#).
- (4) Providing the equipment necessary to implement the RTF infection control policies and procedures.
- 5) Complying with chapter [246-100 WAC](#) "Communicable and certain other diseases."

Nursing Pool.

WAC [246-845-090](#)

Quality assurance standards.

Nursing pools shall comply with the quality assurance standards contained in this section. Evidence of compliance with these standards shall be retained by the nursing pool and be available for inspection by the department for a minimum of three years. These standards are as follows:

- (1) Establishment of a prehire/precontract screening procedure which includes the following:
 - (a) Written or verbal verification of two references relevant to the work the applicant proposes to do for the nursing pool. References must include dates of employment/contracting;
 - (b) Written verification of applicant's current, unrestricted professional license, certificate, or registration issued by the department;
 - (c) Written verification of any certification by a private or public entity in clinical areas relevant to the applicant's proposed work;
 - (d) Written verification of current cardiopulmonary resuscitation certification;
 - (e) Written health screening plan that assures that each applicant is free of tuberculosis, physically able to perform the job duties required for the position, and compliance with OSHA regulations regarding the HBV virus;
 - (f) Compliance with RCW [43.43.830](#) regarding criminal history disclosure and background inquiries;
 - (g) Establishment of a post-hire/post-contract procedure which includes the following:
 - (i) Written procedure for orientation of all new hires/contractors to the nursing pool's policies and procedures prior to beginning work;
 - (ii) Written performance evaluation plan to include written evaluations from facilities regarding performance of persons who have delivered patient care services;
 - (iii) Written continuing education program for personnel/contractors that at a minimum provides educational programs on a variety of related topics relevant to the work performed to include: HIV/HBV information, fire and safety, universal precautions, infection control, and information concerning Washington state abuse reporting requirements;
- (2) Compliance with state and federal wage and labor laws, and federal immigration laws.

Department of Labor and Industries

Recordkeeping and Reporting.

WAC [296-27-01101](#)

Recording criteria.

(1) Basic requirement. Each employer required by this chapter to keep records of fatalities, injuries, and illnesses must record each fatality, injury and illness that:

- Is work-related;
- Is a new case; and
- Meets one or more of the general recording criteria of WAC [296-27-01107](#) or the application to specific cases of WAC [296-27-01109](#) through [296-27-01117](#).

(2) Implementation.

(a) **What sections of this rule describe recording criteria for recording work-related injuries and illnesses?** The table below indicates which sections of the rule address each topic.

(i) Determination of work-relatedness. See WAC [296-27-01103](#).

(ii) Determination of a new case. See WAC [296-27-01105](#).

(iii) General recording criteria. See WAC [296-27-01107](#).

(iv) Additional criteria. (Needlestick and sharps injury cases, **tuberculosis cases**, hearing loss cases, medical removal cases, and musculoskeletal disorder cases). See WAC [296-27-01109](#) through [296-27-01117](#).

(b) **How do I decide whether a particular injury or illness is recordable?** The decision tree for recording work-related injuries and illnesses below shows the steps involved in making this determination.

(c) **May I be required to keep other records or report additional information?** Yes, the director may require that additional records be kept or additional information reported to achieve the purpose of the WISH Act.

WAC [296-27-01103](#)

Determination of work-relatedness.

(1) Basic requirement. You must consider an injury or illness to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a preexisting injury or illness. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures occurring in the work environment, unless an exception in WAC 296-27-01103 (2)(b) specifically applies.

(2) Implementation.

(a) **What is the "work environment"?** Work environment is defined as "the establishment and other locations where one or more employees are working or are present as a condition of their employment. The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of his or her work."

(b) **Are there situations where an injury or illness occurs in the work environment and is not considered work-related?** Yes, an injury or illness occurring in the work environment that falls under one of the following exceptions is not work-related, and therefore is not recordable.

You are **not** required to record injuries and illnesses if:

- At the time of the injury or illness, the employee was present in the work environment as a member of the general public rather than as an employee.
- The injury or illness involves signs or symptoms that surface at work but result solely from a nonwork-related event or exposure that occurs outside the work environment.
- The injury or illness results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, racquetball, or baseball.

- The injury or illness is solely the result of an employee eating, drinking, or preparing food or drink for personal consumption (whether bought on the employer's premises or brought in). For example, if the employee is injured by choking on a sandwich while in the employer's establishment, the case would not be considered work-related.

Note: If the employee is made ill by ingesting food contaminated by workplace contaminants (such as lead), or gets food poisoning from food supplied by the employer, the case would be considered work-related.

- The injury or illness is solely the result of an employee doing personal tasks (unrelated to their employment) at the establishment outside of the employee's assigned working hours.
- The injury or illness is solely the result of personal grooming, self medication for a nonwork-related condition, or is intentionally self-inflicted.
- The injury or illness is caused by a motor vehicle accident and occurs on a company parking lot or company access road while the employee is commuting to or from work.
- The illness is the common cold or flu.

Note: Contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work.

- The illness is a mental illness. Mental illness will not be considered work-related unless the employee voluntarily provides the employer with an opinion from a physician or other licensed health care professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related.

(c) How do I handle a case if it is not obvious whether the precipitating event or exposure occurred in the work environment or occurred away from work? In these situations, you must evaluate the employee's work duties and environment to decide whether or not one or more events or exposures in the work environment either caused or contributed to the resulting condition or significantly aggravated a preexisting condition.

(d) How do I know if an event or exposure in the work environment "significantly aggravated" a preexisting injury or illness? A preexisting injury or illness has been significantly aggravated, for purposes of injury and illness recordkeeping, when an event or exposure in the work environment results in any of the following:

- Death, provided that the preexisting injury or illness would likely not have resulted in death but for the occupational event or exposure.
- Loss of consciousness, provided that the preexisting injury or illness would likely not have resulted in loss of consciousness but for the occupational event or exposure.
- One or more days away from work, or days of restricted work, or days of job transfer that otherwise would not have occurred but for the occupational event or exposure.
- Medical treatment in a case where no medical treatment was needed for the injury or illness before the workplace event or exposure, or a change in medical treatment was necessitated by the workplace event or exposure.

(e) Which injuries and illnesses are considered preexisting conditions? An injury or illness is a preexisting condition if it resulted solely from a nonwork-related event or exposure that occurred outside the work environment.

(f) How do I decide whether an injury or illness is work-related if the employee is on travel status at the time the injury or illness occurs? Injuries and illnesses that occur while an employee is on travel status are work-related if, at the time of the injury or illness, the employee was engaged in work activities "in the interest of the employer." Examples of such activities include travel to and from customer contacts, conducting job tasks, and entertaining or being entertained to transact, discuss, or promote business (work-related entertainment includes only entertainment activities being engaged in at the direction of the employer).

Injuries or illnesses that occur when the employee is on travel status do not have to be recorded if they meet one of the exceptions listed below.

If the employee has:	You may use the following to determine if an injury or illness is work-related.
<ul style="list-style-type: none"> • Checked into a hotel or motel for one or more days 	When a traveling employee checks in to a hotel, motel, or into another temporary residence, he or she establishes a "home away from home." You must evaluate the employee's activities after he or she checks into the hotel, motel, or other temporary residence for their work-relatedness in the same manner as you evaluate the activities of a nontraveling employee. When the employee checks into the temporary residence, he or she is considered to have left the work environment. When the employee begins work each day, he or she reenters the work environment. If the employee has established a "home away from home" and is reporting to a fixed worksite each day, you also do not consider injuries or illnesses work-related if they occur while the employee is commuting between the temporary residence and the job location.
<ul style="list-style-type: none"> • Taken a detour for personal reasons 	Injuries or illnesses are not considered work-related if they occur while the employee is on a personal detour from a reasonably direct route of travel (e.g., has taken a side trip for personal reasons).

(g) How do I decide if a case is work-related when the employee is working at home? Injuries and illnesses that occur while an employee is working at home, including work in a home office, will be considered work-related if the injury or illness occurs while the employee is performing work for pay or compensation in the home, and the injury or illness is directly related to the performance of work rather than to the general home environment or setting. For example, if an employee drops a box of work documents and injures his or her foot, the case is considered work-related. If an employee's fingernail is punctured by a needle from a sewing machine used to perform garment work at home, becomes infected and requires medical treatment, the injury is considered work-related. If an employee is injured because he or she trips on the family dog while rushing to answer a work phone call, the case is not considered work-related. If an employee working at home is electrocuted because of faulty home wiring, the injury is not considered work-related.

WAC [296-27-01115](#)

Recording criteria for work-related tuberculosis cases.

(1) Basic requirement. If any of your employees has been occupationally exposed to anyone with a known case of active tuberculosis (TB), and that employee subsequently develops a tuberculosis infection, as evidenced by a positive skin test or diagnosis by a physician or other licensed health care professional, you must record the case on the OSHA 300 Log by checking the "respiratory condition" column.

(2) Implementation.

(a) **Do I have to record, on the Log, a positive TB skin test result obtained at a preemployment physical?** No, you do not have to record it because the employee was not occupationally exposed to a known case of active tuberculosis in your workplace.

(b) **May I line-out or erase a recorded TB case if I obtain evidence that the case was not caused by occupational exposure?** Yes, you may line-out or erase the case from the Log under the following circumstances:

- The worker is living in a household with a person who has been diagnosed with active TB;
- The public health department has identified the worker as a contact of an individual with a case of active TB unrelated to the workplace; or
- A medical investigation shows that the employee's infection was caused by exposure to TB away from work, or proves that the case was not related to the workplace TB exposure.

WAC [296-27-01119](#)

Forms.

(1) Basic requirement. You must use OSHA 300, 300-A, and 301 forms, or equivalent forms, for recordable injuries and illnesses. The OSHA 300 form is called the Log of Work-Related Injuries and Illnesses, the 300-A is the Summary of Work-Related Injuries and Illnesses, and the OSHA 301 form is called the Injury and Illness Incident Report.

(2) Implementation.

(a) **What do I need to do to complete the OSHA 300 Log?** You must enter information about your business at the top of the OSHA 300 Log, enter a one or two line description for each recordable injury or illness, and summarize this information on the OSHA 300-A at the end of the year.

(b) **What do I need to do to complete the OSHA 301 Incident Report?** You must complete an OSHA 301 Incident Report form, or an equivalent form, for each recordable injury or illness entered on the OSHA 300 Log.

(c) **How quickly must each injury or illness be recorded?** You must enter each recordable injury or illness on the OSHA 300 Log and 301 Incident Report within seven calendar days of receiving information that a recordable injury or illness has occurred.

(d) **What is an equivalent form?** An equivalent form is one that has the same information, is as readable and understandable, and is completed using the same instructions as the OSHA form it replaces. Many employers use an insurance form instead of the OSHA 301 Incident Report, or supplement an insurance form by adding any additional information listed on the OSHA form.

(e) **May I keep my records on a computer?** Yes, if the computer can produce equivalent forms when they are needed, as described under WAC [296-27-02111](#) and [296-27-03103](#), you may keep your records using the computer system.

(f) **Are there situations where I do not put the employee's name on the forms for privacy reasons?** Yes, if you have a "privacy concern case," you may not enter the employee's name on the OSHA 300 Log. Instead, enter "privacy case" in the space normally used for the employee's name. This will protect the privacy of the injured or ill employee when another employee, a former employee, or an authorized employee representative is provided access to the OSHA 300 Log under WAC [296-27-02111](#). You must keep a separate, confidential list of the case numbers and employee names for your privacy concern cases so you can update the cases and provide the information to the government if asked to do so.

(g) **How do I determine if an injury or illness is a privacy concern case?** You must consider the following injuries or illnesses to be privacy concern cases:

- An injury or illness to an intimate body part or the reproductive system;
- An injury or illness resulting from a sexual assault;
- Mental illnesses;

• HIV infection, hepatitis, or tuberculosis;

- Needlestick injuries and cuts from sharp objects that are contaminated with another person's blood or other potentially infectious material (WAC [296-27-01109](#) for definitions); **and**
- Other illnesses if the employee independently and voluntarily requests that his or her name not be entered on the log.

(h) **May I classify any other types of injuries and illnesses as privacy concern cases?** No, this is a complete list of all injuries and illnesses considered privacy concern cases for the purposes of this section.

(i) **If I have removed the employee's name, but still believe that the employee may be identified from the information on the forms, is there anything else that I can do to further protect the employee's privacy?** Yes, if you have a reasonable basis to believe that information describing the privacy concern case may be personally identifiable even though the employee's name has been omitted, you may use discretion in describing the injury or illness on both the OSHA 300 and 301 forms. You must enter enough information to identify the cause of the incident and the general severity of the injury or illness, but you do not need to include details of an intimate or private nature. For example, a sexual assault case could be described as "injury from assault," or an injury to a reproductive organ could be described as "lower abdominal injury."

(j) **What must I do to protect employee privacy if I wish to provide access to the OSHA Forms 300 and 301 to persons other than government representatives, employees, former employees or authorized representatives?** If you decide to voluntarily disclose the forms to persons other than government representatives, employees, former employees or authorized representatives (as required by WAC [296-02111](#) and [296-27-03103](#)), you must remove or hide the employees' names and other personally identifying information, except for the following cases. You may disclose the forms with personally identifying information only:

- (i) To an auditor or consultant hired by the employer to evaluate the safety and health program;
- (ii) To the extent necessary for processing a claim for workers' compensation or other insurance benefits; or
- (iii) To a public health authority or law enforcement agency for uses and disclosures for which consent, an authorization, or opportunity to agree or object is not required under Department of Health and Human Services Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. 164.512.

(3) Falsification, failure to keep records or reports.

(a) RCW [49.17.190](#)(2) of the act provides that "whoever knowingly makes any false statement, representation, or certification in any application, record, report, plan, or other document filed or required to be maintained pursuant to this chapter shall, upon conviction be guilty of a gross misdemeanor and be punished by a fine of not more than ten thousand dollars, or by imprisonment for not more than six months or by both."

(b) Failure to maintain records or file reports required by this chapter, or in the detail required by the forms and instructions issued under this chapter, may result in the issuance of citations and assessment of penalties as provided for in chapter [296-900](#) WAC, Administrative rules.

Safety Standards for Firefighters.

WAC [296-305-02501](#)

Emergency medical protection.

(1) Firefighters who perform emergency medical care or otherwise may be exposed to blood or other body fluids shall be provided with emergency medical face protection devices, and emergency medical

garments that meet the applicable requirements of the 1999 edition of NFPA 1999, Standard on Protective Clothing for Emergency Medical Operations.

Note: Prior to purchase, fire departments should request the technical data package required in the 2003 edition of NAPA 1999, in order to compare glove and garment performance data. Departments reviewing these packages should ensure a relative ranking of the performance data before they purchase in order to provide the best performance of the EMS personal protective clothing.

(2) Firefighters shall don emergency medical gloves and eye protection prior to initiating any emergency patient care.

(3) Firefighters shall don emergency medical garments prior to any patient care during which splashes of body fluids can occur such as situations involving spurting blood or childbirth.

Note: Firefighter turnout gear and gloves with vapor barriers may be used in lieu of emergency medical gloves and garments.

(4) Contaminated emergency medical garments, emergency medical face and eye protection, gloves, devices, and emergency medical gloves shall be cleaned and disinfected, or disposed of, in accordance with chapter [296-823](#) WAC, Occupational exposure to bloodborne pathogens.

(5) Fire departments shall establish a designated infection (exposure) control officer who shall ensure that an adequate infection control plan is developed and all personnel are trained and supervised on the plan.

(6) The infection control officer shall be responsible for establishing personnel exposure protocols so that a process for dealing with exposures is in writing and available to all personnel.

(7) The infection control officer or his/her designee will function as a liaison between area hospitals and fire department members to provide notification that a communicable disease exposure is suspected or has been determined by hospital medical personnel. The department infection control officer will institute the established exposure protocols immediately after report of an exposure. The infection control officer shall follow the confidentiality requirements of chapter [246-100](#) WAC and the medical protocol requirements of chapter [296-802](#) WAC.

(8) Fire departments shall have a written infection control plan which clearly explains the intent, benefits, and purpose of the plan. The written document must cover the standards of exposure control such as establishing the infection control officer and all members affected; education and training; documentation and record keeping; cleaning/disinfection of personnel and equipment; and exposure protocols.

(9) Policy statements and standard operating procedure guidelines shall provide general guidance and specific regulation of daily activities. Procedures shall include delegation of specific roles and responsibilities, such as regulation of infection control, as well as procedural guidelines for all required tasks and functions.

(10) Fire departments shall establish a records system for members health and training.

(11) Firefighters shall be trained in the proper use of P.E., exposure protection, post exposure protocols, disease modes of transmission as it related to infectious diseases.

(12) Infectious disease programs shall have a process for monitoring firefighters compliance with established guidelines and a means for correcting noncompliance.

(13) Fire department members shall be required to annually review the infectious disease plan, updates, protocols, and equipment used in the program.

(14) Fire departments shall comply with chapter [296-823](#) WAC, Occupational exposure to bloodborne pathogens, in its entirety.

(15) Tuberculosis (TB) exposure and respiratory protection requirements.

(a) Firefighters shall wear a particulate respirator (PR) when entering areas occupied by individuals with suspected or confirmed TB, when performing high risk procedures on such individuals or when transporting individuals with suspected or confirmed TB in a closed vehicle.

(b) A NIOSH-approved, 95% efficient particulate air respirator is the minimum acceptable level of respiratory protection.

(i) Fit tests are required.

(ii) Fit tests shall be done in accordance with chapter [296-842 WAC](#).

(c) Employee tuberculosis screening shall be provided in accordance with current U.S. Centers for Disease Control and Prevention guidelines.

Note: If possible, the rear windows of a vehicle transporting patients with confirmed, suspected, or active tuberculosis should be kept open, and the heater or air conditioner set on a noncirculating cycle.

Safety Standards for Agriculture.

WAC [296-307-60205](#)

Select and provide appropriate respirators.

IMPORTANT:

See WAC [296-307-624](#), Respiratory hazards, for:

- Hazard evaluation requirements. Evaluation results are necessary for respirator selection.
- A list of substance-specific rules that may also apply to you. Those listed rules have additional respirator selection requirements.

You must:

- Select and provide, at no cost to employees, appropriate respirators for routine use, infrequent use, and reasonably foreseeable emergencies (such as escape, emergency, and spill response situations) by completing the following process:

Respirator Selection Process

Step 1: If your only respirator use is for escape, skip to **Step 8** to select appropriate respirators.

Step 2: If the respiratory hazard is a biological aerosol, such as TB (tuberculosis), anthrax, psittacosis (parrot fever), or hanta virus, select a respirator appropriate for **nonemergency** activities recognized to present a health risk to workers AND skip to **Step 8**.

- If respirator use will occur during **emergencies**, skip to **Step 8** and document the analysis used to select the appropriate respirator.
- Use Centers for Disease Control (CDC) selection guidance for exposures to specific biological agents when this guidance exists. Visit <http://www.cdc.gov>.

Step 3: If the respiratory hazard is a pesticide, follow the respirator specification on the pesticide label AND skip to **Step 9**.

Step 4: Determine the expected exposure concentration for each respiratory hazard of concern. Use the results from the evaluation required by WAC [296-307-624](#), Respiratory hazards.

Step 5: Determine if the respiratory hazard is classified as IDLH; if it is NOT IDLH skip to **Step 7**.

- The respiratory hazard is classified as IDLH if:
 - The atmosphere is oxygen deficient or oxygen enriched
- or
- You CANNOT measure or estimate your expected exposure concentration

or

- Your measured or estimated expected exposure concentration is greater or equal to the IDLH value in the NIOSH *Pocket Guide to Chemical Hazards*

- Note:**
- WISHA uses the IDLH values in the 1990 edition of the NIOSH *Pocket Guide to Hazardous Chemicals* to determine the existence of IDLH conditions. You may use more recent editions of this guide. Visit www.cdc.gov/niosh for more information.
 - If your measured or estimated expected exposure concentration is below NIOSH's IDLH values,

proceed to **Step 7**.

Step 6: Select an appropriate respirator from one of the following respirators for IDLH conditions and skip to **Step 8**:

- Full-facepiece, pressure demand, self-contained breathing apparatus (SCBA) certified by NIOSH for a minimum service life of thirty minutes

OR

- Full-facepiece, pressure demand air-line respirator equipped with an auxiliary self-contained air supply

Exception: If the respiratory hazard is oxygen deficiency AND you can show oxygen concentrations can be controlled within the ranges listed in Table 4 under ALL foreseeable conditions, you are allowed to select **any** type of SCBA or air-line respirator.

Step 7: Identify respirator types with assigned protection factors (APFs) from Table 5 that are appropriate to protect employees from the expected exposure concentration.

Step 8: Consider hazards that could require selection of specific respirator types. For example, select full-facepiece respirators to prevent eye irritation or abrasive blasting helmets to provide particle rebound protection.

Step 9: Evaluate user and workplace factors that might compromise respirator performance, reliability or safety.

- If the respiratory hazard is a pesticide, follow the requirements on the pesticide label and skip to **Step 11**.

Examples:

- High humidity or temperature extremes in the workplace.
- Necessary voice communication.
- High traffic areas and moving machinery.
- Time or distance for escape.

Step 10: Follow Table 6 requirements to select an air-purifying respirator.

- If Table 6 requirements cannot be met, you must select an air-line respirator or an SCBA.

Step 11: Make sure respirators you select are certified by the National Institute for Occupational Safety and Health (NIOSH).

- To maintain certification, make sure the respirator is used according to cautions and limitations specified on the NIOSH approval label.

Note: While selecting respirators, you will need to select a sufficient number of types, models or sizes to provide for fit testing. You can also consider other respirator use issues, such as accommodating facial hair with a loose fitting respirator.

WAC 296-307-62005

Use this medical questionnaire for medical evaluations.

You must:

- Use the medical questionnaire in Table 10 when conducting medical evaluations.

Note:

- You may use a physical exam instead of this questionnaire if the exam covers the same information as the questionnaire.
- You may use online questionnaires if the questions are the same and the requirements in WAC [296-307-604](#) of this part are met.
- You may choose to send the questionnaire to the LCHP ahead of time, giving time to review it and add any necessary questions.
- The LHCP determines what questions to add to the questionnaire, if any; however, questions in Parts 1-3 may not be deleted or substantially altered.

Respirators.

WAC [296-842-22005](#)

Use this medical questionnaire for medical evaluations.

Use the medical questionnaire in Table 10 when conducting medical evaluations.

- Note:**
- You may use a physical exam instead of this questionnaire if the exam covers the same information as the questionnaire.
 - You may use online questionnaires if the questions are the same and the requirements in WAC [296-842-14005](#) of this chapter are met.
 - You may choose to send the questionnaire to the LHCP ahead of time, giving time to review it and add any necessary questions.
 - The LHCP determines what questions to add to the questionnaire, if any; however, questions in Parts 1-3 may not be deleted or substantially altered.

Board of Pilotage Commissioners

Pilotage Rules.

WAC [363-116-120](#)

Job description—Physical examination—Health requirements.

(1) A Washington state licensed marine pilot, under the authority of the master, directs ships into and out of harbors, estuaries, straits, sounds, rivers, lakes, and bays using a specialized knowledge of local conditions including winds, weather, tides, and current: Orders officers and helmsman by giving course and speed changes and navigates ship to avoid conflicting marine traffic, congested fishing fleets, reefs, outlying shoals and other hazards to shipping; utilizes aids to navigation, such as lighthouses and buoys. Utilizes ship's bridge equipment, including radar, fathometer, speed log, gyro, magnetic compass, whistle or horn and other navigational equipment as needed. Required to use ship's radio equipment in contacting United States Coast Guard vessel traffic system and other ships while ship is in transit. Directs ship's officers, crewmen, and tug boat captains as necessary, when ships are transiting bridges, narrow waterways, anchoring, docking, and undocking. Must perform duties day or night in all weather conditions, including high winds, fog, mist, rainfall, falling snow and other adverse conditions, as encountered. In order to safely perform the foregoing duties, a Washington state licensed marine pilot shall:

- (a) Be physically qualified to possess a U.S. Coast Guard master's license, as required by the state of Washington.
- (b) Be capable of boarding a vessel from and leaving a vessel into a pilot boat via a Jacob's ladder and a gangway. A Jacob's ladder involves a vertical climb or descent of up to nine meters and requires both physical energy and mental judgment.
- (c) Be capable of moving to a more desirable vantage point in a timely manner, so as to avoid a close quarters situation when the physical characteristics of the ship or cargo obstruct the pilot's field of vision.
- (d) Be able to meet the necessary eyesight and hearing requirements to carry out marine pilotage duties.
- (e) Have mental reflexes capable of allowing decisions to be made without delay. This is imperative in all aspects of ship handling.

(f) Be capable of withstanding mental stresses which may occur with a vessel in lowered visibility, in a close quarters situation or when docking or undocking.

(g) Be capable of working efficiently and effectively at any time of the day or night, including irregular and unscheduled hours, after sufficient rest.

(h) Possess mental maturity and show mental responsibility.

(2) In order to determine the physical fitness of persons to serve as licensed pilots under the provisions of the pilotage act, all licensed pilots and pilot applicants shall be required to pass a general physical examination annually within ninety days prior to the date their annual state pilot license fee is due. As used in this section pilot refers to licensed pilots, including pilots seeking to renew their state licenses, and pilot applicant refers to both pilot license applicants who have completed the board training program but do not yet have a pilot license and to training license applicants. The physical examination required of all pilots and initial pilot applicants shall demonstrate that he/she is fully able to carry out the duties of a pilot. The examination shall assure that one's abilities as a pilot will not be impaired by eyesight, hearing or other bodily function. As part of this examination pilots and pilot applicants shall have completed on a form provided by the board a detailed report of physical examination. Each pilot is required to report on the form any convictions of offenses involving drugs or the personal consumption of alcohol which occurred while on duty within the prior twelve months. Pilot applicants for a license must report on the form any and all convictions of offenses involving drugs or the personal consumption of alcohol which occurred within the twelve months prior to the date of their application. This form shall be prepared by the examining physician and shall be submitted to the board along with a letter stating his/her findings/recommendations as to the ability of the pilot or pilot applicant to safely perform the pilotage duties based on the job description for a Washington state licensed marine pilot and the standards set forth below. The examining physician should review these standards and review the job description in subsection (1) of this section before making findings/recommendations as to the medical fitness of the pilot applicant. A medical/occupational history form will be completed and signed by the initial pilot applicant for review by the physician prior to the initial examination. The board may in its discretion check with the appropriate authorities for any convictions of offenses involving drugs or the personal consumption of alcohol in the prior twelve months. The detailed report of physical examination is a confidential record and will not be available for public inspection. Such examination shall be obtained at the expense of the licensed pilot or pilot applicant from a physician or physicians designated in advance by the board. The secretary of the board shall give each pilot or pilot applicant reasonable written notice of the date when any such physical examination becomes due and shall specify the name of the physicians then approved by the board to conduct such physical examination.

(3) Based upon the findings/recommendations of the examining physician and review by the board, the board will make the determination as to the pilot applicant's or pilot's fitness to perform the duties of a pilot. This determination will be made within ninety days after each annual physical examination.

(4) The purpose of the history and physical examination is to detect the presence of physical, mental, or organic defects of such character and extent as to affect an individual's ability to pilot a vessel safely. The examination will be made carefully and at least as complete as indicated by the form provided by the board. History of certain defects may be cause for rejection of the initial pilot applicant or indicate the need for making certain laboratory tests or a further and more stringent examination. Defects may be recorded which do not, because of their character or degree, indicate that certification of physical fitness should be denied. However, these defects should be discussed with the pilot applicant or pilot who should be advised to take the necessary steps to ensure correction, particularly of those which, if neglected, might lead to a condition likely to affect the ability to perform the duties of a pilot.

(5) The board has determined which physical conditions may be permanently disqualifying for initial pilot applicants as well as which conditions may be permanently disqualifying for renewal of a pilot license. Certain conditions are not necessarily disqualifying, for renewal of a pilot license only, when,

based on the knowledge and experience of the examining physician these conditions can be managed medically and without threat to the pilot's ability to perform the duties of a pilot. An individual may be disqualified when, in the opinion of the examining physician, there is reasonable probability that a condition can occur suddenly and without warning which would render the pilot applicant incapable of promptly responding, both mentally and physically to emergency situations. When certain conditions exist the medical examiner may recommend either:

- (a) A permanent disqualification; or
- (b) A temporary disqualification until which time the condition is either corrected or medically managed.
- (6) Initial pilot applicants will be required to take a test indicating they are free of illegal substance abuse. Testing will be for the presence of cocaine, opiates, marijuana (THC), amphetamines and PCP (phencyclidine). Testing will be in accordance with the Department of Transportation (Coast Guard) guidelines outlined in the Federal Register 46 C.F.R. 4, 5, and 16. Urine specimens are to be analyzed by a laboratory that meets DHHS regulations set forth by the National Institute of Drug Abuse (NIDA). Chain of custody forms and instructions for collection and transport to a NIDA approved laboratory can be obtained from:

Laboratory of Pathology
Nordstrom Medical Tower
P.O. Box 14950
Seattle, WA 98114-0950
[206-386-2872](tel:206-386-2872)

(7) The conditions in these standards are listed according to the International Classification of Diseases (ICD). Some categories may not apply to the standards set forth and therefore may be absent in some listings. However, all categories should be taken into consideration by the examining physician.

- (a) Infectious and parasitic diseases.
- (b) Neoplasms.
- (c) Endocrine, nutritional, metabolic, and immunity disorders.
- (d) Diseases of the blood and blood forming organs.
- (e) Mental disorders.
- (f) Diseases of the nervous system and sense organs.
- (g) Diseases of the respiratory system.
- (h) Diseases of the digestive system.
- (i) Diseases of the genitourinary system.
- (j) Complications of pregnancy, childbirth, and the puerperium.
- (k) Diseases of the skin and subcutaneous tissues.
- (l) Diseases of the musculoskeletal system and connective tissues.
- (m) Congenital anomalies.
- (n) Certain conditions originating in the perinatal period.
- (o) Symptoms, signs, and other ill defined conditions.
- (p) Injury and poisonings.

(8) The guidelines for recommended visual standards are based on the necessity of a pilot to be able to safely perform the duties of a pilot, including functioning under all emergency conditions aboard the vessel. Consideration must be given to the pilot's previously demonstrated ability to perform his/her pilotage duties.

(a) The visual acuity of a pilot applicant shall be at least 20/200 in each eye uncorrected and correctable to at least 20/40 in each eye as determined by Snellen test or its equivalent unless the pilot applicant qualifies for a waiver from the Officer in Charge, Marine Inspection, or the Commandant, U.S. Coast Guard.

(b) The initial pilot applicant should have normal color vision per pseudo isochromatic plates, Ishihara or Keystone test. If the initial pilot applicant fails this test, the Farnsworth or Williams Lantern tests or their equivalent may be used to determine the initial pilot applicant's ability to distinguish primary colors.

(c) Loss of vision in one eye may not be disqualifying if one eye passes the test required for the better eye of the pilot applicant with binocular vision and the pilot applicant has had sufficient time to develop and demonstrate adequate judgment of distances.

(d) Pilot applicants who wear corrective lenses and meet the qualifications in (a) of this subsection are medically fit to carry out pilotage duties only while wearing their corrective lenses and if they have with them, while on duty, a spare pair of correcting lenses that provide at least the same visual acuity.

(9) Baseline audiograms shall be performed on all entry level pilot applicants. All licensed pilots will be tested annually, with the first audiogram considered baseline. Each ear will be tested separately using properly calibrated equipment which meets ANSI (American National Standards Institute) standards criteria for background noise in audiometric rooms. Testing should not be performed unless the pilot applicant has been free of work noise or intense noise for a period of at least fourteen hours prior to testing. Should the pilot applicant have a current condition which can cause a temporary hearing loss, such as a cold, the pilot applicant should be rescheduled for testing in two weeks, or until such condition is resolved. Testing will be performed by a licensed audiologist, otolaryngologist, physician with sufficient training in conducting and interpreting audiograms, or a technician who is currently certified by the Council for Accreditation in Occupational Hearing Conservation (CAOHC).

(a) A baseline audiogram is required on all initial pilot applicants. The first audiogram performed on a currently licensed pilot shall be considered the baseline audiogram.

(b) Pilot applicants having hearing threshold levels that do not exceed 40 dB at frequencies of 500, 1000, 2000, 3000 Hz in either ear are considered to have normal hearing for communication purposes.

(c) Annual audiograms will be performed thereafter for the purposes of comparison to baseline. A significant threshold shift is defined as a change averaging more than 10 dB from baseline in the frequencies of 500, 1000, 2000, and 3000 Hz and requires further evaluation by a physician, otolaryngologist, or audiologist and preventive action taken on the part of the pilot.

(d) Mechanical acoustical devices (hearing aids) are not disqualifying but should not be worn in areas of high background noise levels in order to prevent further deterioration of his/her hearing.

(e) A pilot applicant must minimally be able to hear an average conversational voice in a quiet room while standing with his/her back turned at a distance of eight feet.

(10) Below is a list of conditions which can be absolutely disqualifying for initial licensure as a maritime pilot. The list of causes for disqualification is not all inclusive or intended to be complete, but represents the types of conditions that would interfere with the safe performance of pilotage duties. This guide is not intended to replace the physician's professional judgment. Rather, it calls for the physician and the board to closely examine whether the pilot applicant can safely perform the tasks outlined in the job description of a Washington state licensed marine pilot. The examining physician should also be aware that a second opinion concerning the diagnosis may be sought in cases of unfavorable determinations. A condition should only be considered disqualifying while such condition persists. Following corrective medical action the pilot applicant should be encouraged to apply for reentry.

Conditions Which Can Be Absolutely Disqualifying For Initial Licensure

1. Infectious and parasitic diseases - Any communicable disease in its communicable or carrier stage.
2. Neoplasms - Malignant diseases of all kinds in any location.
3. Endocrine, nutritional, metabolic, and immunity disorders - Diabetes requiring insulin or hypoglycemic drugs; cirrhosis of the liver; alcohol abuse (unless abstinence for two years).
4. Diseases of the blood and blood forming organs - Hemophilia; acute or chronic significant anemias.

5. Mental disorders - Severe personality disorders; use of illegal drugs; dementia of Alzheimer's type, senility, psychosis.
6. Diseases of the nervous system and sense organs - Epilepsy or any convulsive disorder resulting in an altered state of consciousness, regardless of control; disturbance of balance; multiple sclerosis; Meniere's syndrome.
7. Diseases of the circulatory system - Multiple myocardial infarctions or cardiac class II or IV (NYHA); hypotension with syncopal episodes; varicose veins if associated with edema, skin ulceration or residual scars. Recurrent thromboembolic conditions.
8. Diseases of the respiratory system - Active pulmonary tuberculosis Class IV respiratory impairment; permanent tracheostomy.
9. Diseases of the genitourinary system - Chronic renal failure; permanent ureterostomy.
10. Complications of pregnancy, childbirth, and the puerperium - Pregnancy is not in itself disqualifying, if, in the opinion of the examining physician and the pilot applicant's obstetrician determine that the pilotage duties can be safely carried out without risk to the mother or fetus and without risk to the safety of the vessel, crew, and property.
11. Diseases of the skin and subcutaneous tissues - There are no absolute exclusions listed for diseases of the skin unless, in the opinion of the examining physician, a condition exists that would interfere with the performance of pilotage duties.
12. Diseases of the musculoskeletal system and connective tissues - Lupus erythematosus, disseminated; amputation of any portion of a limb, resection of a joint, artificial joint or absence of the toes which would preclude the ability to run, walk, balance oneself, grasp and climb ladder rungs; chronic low back pain that is disabling to the degree of interfering with job requirements.
13. Congenital anomalies - Any existing condition that, in the opinion of the examining physician, would interfere with the safe performance of pilotage duties.
14. Symptoms, signs, and other ill defined conditions - Serious degree of stuttering or speech impediment sufficient to interfere with communication; alcoholism; drug addiction, other than tobacco or caffeine.
15. Injury or poisonings - May be temporarily disqualifying until condition resolved without disabling sequelae.

(11) Below is a list of conditions which can be absolutely disqualifying for relicensure as a maritime pilot. The list of causes for disqualification is not all inclusive or intended to be complete, but represent the types of conditions that would interfere with the safe performance of pilotage duties. This guide is not intended to replace the physician's professional judgment. Rather, it calls for the physician and the board to closely examine whether the pilot applicant can continue to safely perform the tasks outlined in the job description of a Washington state licensed marine pilot. The examining physician should also be aware that a second opinion concerning diagnosis may be sought in cases of unfavorable determinations.

Conditions Which Can Be Absolutely Disqualifying For Relicensure

1. Neoplasms - Malignancies with metastases.
2. Endocrine, nutritional, metabolic, and immunity disorders - Cirrhosis of the liver with hepatic failure.
3. Diseases of the blood and blood forming organs - Hemophilia; acute leukemia.
4. Mental disorders - Severe personality disorders; senility; dementia of Alzheimer's type psychosis.
5. Diseases of the nervous system and sense organs - Disturbance of balance, permanent and untreatable Meniere's syndrome.
6. Diseases of the circulatory system - Multiple myocardial infarctions or cardiac Class III or IV (NYHA); hypotension with syncopal episodes; varicose veins if associated with edema, skin ulceration or residual scars. Recurrent thromboembolic conditions.

7. Diseases of the respiratory system - Active pulmonary tuberculosis; Class IV respiratory impairment.

8. Diseases of the genitourinary system - Chronic renal failure; permanent ureterostomy.

9. Complications of pregnancy, childbirth, and puerperium - Pregnancy is not in itself disqualifying, if, in the opinion of the examining physician and the pilot applicant's obstetrician determine that the pilotage duties can be safely carried out without risk to the mother or fetus and without risk to the safety of the vessel, crew and property.

10. Diseases of the skin and subcutaneous tissues - There are no absolute exclusions for diseases of the skin unless, in the opinion of the examining physician, a condition exists that would interfere with the performance of pilotage duties.

11. Diseases of the musculoskeletal and connective system - Lupus erythematosus, disseminated; amputation of any portion of a limb, resection of a joint, artificial joint or absence of the toes which would preclude the ability to run, walk, balance oneself, grasp, and climb ladder rungs. Chronic low back pain that is disabling to the degree of interfering with job requirements.

12. Symptoms, signs, and other ill defined conditions - Serious degree of stuttering or speech impediment sufficient to interfere with communication; alcoholism; drug addiction, other than tobacco or caffeine. Current need to use methadone, antabuse, antidepressants, antianxiety drugs.

13. Injury or poisonings - May be temporarily disqualifying until condition resolved without disabling sequelae.

(12) Some conditions may develop during the course of employment that would be absolutely disqualifying for initial licensure. In evaluating the impact of such a condition on an existing pilot, the examining physician and the board should take into consideration the pilot's past experience, effectiveness of performance and predictability of his/her performance. The board may waive certain duties of a pilot as outlined in the job description contained in subsection (1) of this section. The list of conditions requiring in-depth evaluation is not all inclusive or intended to be complete, but represent the types of conditions that might interfere with the safe performance of pilotage duties. The examining physician should also be aware that a second opinion concerning the diagnosis may be sought in cases of unfavorable determinations.

Conditions Requiring In-depth Evaluation

1. Neoplasms - Malignancies of any kind.

2. Endocrine, nutritional, metabolic, and immunity disorders - Diabetes requiring hypoglycemic drugs; cirrhosis of the liver.

3. Diseases of the blood and blood forming organs - Chronic leukemia.

4. Mental disorders - Anxiety reactions; depression.

5. Diseases of the nervous system and sense organs - Disturbance of balance; multiple sclerosis; epilepsy or any convulsive disorder resulting in an altered state of consciousness.

6. Diseases of the circulatory system - Uncontrolled hypertension; varicose veins; pacemaker, demand.

7. Diseases of the respiratory system - Respiratory impairment; permanent tracheostomy.

8. Diseases of the digestive system - Permanent colostomy; permanent ileostomy.

9. Complications of pregnancy, childbirth, and the puerperium - Pregnancy.

10. Diseases of the skin and subcutaneous tissues - Any skin disorders that, in the opinion of the examining physician, may interfere with the performance of pilotage duties.

11. Diseases of the musculoskeletal system and connective tissues - Lupus erythematosus, disseminated; artificial joints; chronic low back pain.

12. Injury or poisonings - May be temporarily disqualifying until condition resolved without disabling sequelae.

(13) A pilot may be temporarily relieved of pilotage duties until such time as a disqualifying condition is resolved or medically managed and with frequent evaluation by the examining physician or specialist. In this case, the board, after consulting with the physician, will determine the frequency of medical

examinations. A condition should only be considered disqualifying while such a condition persists. Following corrective medical action, the individual may be removed from temporary disqualification. Provided that, if a temporary disqualifying condition continues for longer than two years from the time the pilot is initially relieved of pilotage duties, the board, in its discretion and after a full review of all relevant factors, may make a determination that the condition is permanently disqualifying.

Department of Social and Health Services

Home and Community Services and Programs.

WAC [388-71-0750](#)

Adult day centers—Personnel policies and procedures.

- (1) Personnel policies and procedures must be in place to ensure that staff are trained and knowledgeable to provide quality services in a safe environment. Policies must include at least the following:
 - (a) The center must have policies concerning the recruitment, orientation, training, evaluation, and professional development of staff and volunteers.
 - (b) The center must have job descriptions for each paid staff and volunteer position that are in accordance with ADA requirements and that specify qualifications for the job, delineation of tasks, and lines of supervision and authority.
 - (c) Each employee must receive, review, and sign a copy of the job description at the time of employment and whenever job descriptions are modified. Volunteers who function as staff must receive written descriptions of responsibilities.
 - (d) Probationary evaluations and annual performance evaluations, in accordance with job descriptions, must be conducted and must conform to the policy of the funding or parent organization. Both the employee and supervisor will sign the written evaluation. Copies will be kept in locked personnel files.
 - (e) Each staff person is to have a tuberculin test within thirty days of employment. If a test has been performed within twelve months of employment, the results of that test may be accepted. Tuberculin tests will be repeated according to local public health requirements.
 - (f) The center must have policies to restrict a staff person or participant's contact with clients when the staff person or participant has a known communicable disease in the infectious stage that is likely to spread in the center.
 - (g) Policies must also be established concerning hand washing, universal precautions, infection control, infectious waste disposal, bloodborne pathogens, and laundry and handling of soiled and clean items.
- (2) The center must have policies and procedures concerning suspected abuse, neglect, or exploitation reporting that include provisions preventing access to any participant until the center investigates and takes action to assure the participant's safety.
- (3) The center must not interfere with the lawful investigation of a complaint, coerce a participant, or conceal evidence of alleged improprieties occurring within the center.
- (4) The center must have policies that meet the requirements of mandatory reporting procedures as described in chapter [74.34](#) RCW to adult protective services for vulnerable adults and to local law enforcement for other participants.
- (5) Each employee must receive or have access to a copy of the program's personnel policies at the time of employment.
- (6) Whenever volunteers function in the capacity of staff, all applicable personnel policies must pertain.
- (7) The center must conform to federal and state labor laws and be in compliance with equal opportunity guidelines.

WAC 388-71-0760

Adult day centers—Employee records.

(1) Each employee must have an individual file containing the employee's application, verification of references, TB status, signed job description, and all performance evaluations. Copies of current license or certificate and verification of current good standing, and certification of CPR and first aid training, if applicable, must also be in the file.

(2) Centers must maintain employee records for the duration of staff employment and at least seven years after termination of employment.

(3) Employee records must contain all records of training, such as staff orientation and training pertinent to duties or regulatory compliance, including CPR, first aid, and universal precautions training.

(4) Employee records must contain criminal history disclosure and background checks.

Adult Family Homes Minimum Licensing Requirements.

WAC 388-76-10130

Qualifications—Provider, entity representative and resident manager.

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

(1) Be twenty-one years of age or older;

(2) Have a United States high school diploma or general education development certificate, or any English translated government document of the following:

(a) Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction;

(b) Graduation from a foreign college, foreign university, or United States community college with a two-year diploma, such as an associate's degree;

(c) Admission to, or completion of course work at a foreign or United States college or university for which credit was awarded;

(d) Graduation from a foreign or United States college or university, including award of a bachelor's degree;

(e) Admission to, or completion of postgraduate course work at, a United States college or university for which credits were awarded, including award of a master's degree; or

(f) Successful passage of the United States board examination for registered nursing, or any professional medical occupation for which college or university education was required.

(3) Completion of the training requirements that were in effect on the date they were hired or became licensed providers, including the requirements described in chapter [388-112](#) WAC;

(4) Have good moral and responsible character and reputation;

(5) Be literate and able to communicate in the English language, and assure that a person is on staff and available at the home who is capable of understanding and speaking English well enough to be able to respond appropriately to emergency situations and be able to read, understand and implement resident negotiated care plans.

(6) Assure that there is a mechanism to communicate with the resident in his or her primary language either through a qualified person on-site or readily available at all times, or other reasonable accommodations, such as a language line.

(7) Be able to carry out the management and administrative requirements of chapters [70.128](#), 70.129 and [74.34](#) RCW, this chapter and other applicable laws and regulations;

(8) Have completed at least one thousand hours of successful direct care experience in the previous sixty months obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home. Individuals holding one of the following professional licenses are exempt from this requirement:

- (a) Physician licensed under chapter [18.71](#) RCW;
- (b) Osteopathic physician licensed under chapter [18.57](#) RCW;
- (c) Osteopathic physician assistant licensed under chapter [18.57A](#) RCW;
- (d) Physician assistant licensed under chapter [18.71A](#) RCW;
- (e) Registered nurse, advanced registered nurse practitioner, or licensed practical nurse licensed under chapter [18.79](#) RCW.

(9) Have no disqualifying criminal convictions or pending criminal charges under chapter [388-113](#) WAC;

(10) Have none of the negative actions listed in WAC [388-76-10180](#);

(11) Obtain and keep valid cardiopulmonary resuscitation (CPR) and first-aid card or certificate as required in chapter [388-112](#) WAC; and

(12) Have tuberculosis screening to establish tuberculosis status per this chapter.

WAC [388-76-10135](#)

Qualifications—Caregiver

The adult family home must ensure each caregiver has the following minimum qualifications:

(1) Be eighteen years of age or older;

(2) Have a clear understanding of the caregiver job responsibilities and knowledge of each resident's negotiated care plan to provide care specific to the needs of each resident;

(3) Have basic communication skills to:

(a) Be able to communicate or make provisions to communicate with the resident in his or her primary language;

(b) Understand and speak English well enough to:

(i) Respond appropriately to emergency situations; and

(ii) Read, understand and implement resident negotiated care plans.

(4) Completion of the training requirements that were in effect on the date they were hired including requirements described in chapter [388-112](#) WAC;

(5) Have no disqualifying criminal convictions or pending criminal charges under chapter [388-113](#) WAC;

(6) Have none of the negative actions listed in WAC [388-76-10180](#);

(7) Have a current valid first-aid and cardiopulmonary resuscitation (CPR) card or certificate as required in chapter [388-112](#) WAC; and

(8) Have tuberculosis screening to establish tuberculosis status per this chapter.

WAC [388-76-10140](#)

Qualifications—Students – Volunteers

The adult family home must ensure that students and volunteers meet the following minimum qualifications:

(1) Be eighteen years old or older;

(2) Meet the department's training requirements of chapter [388-112](#) WAC;

(3) Have no criminal convictions listed in RCW [43.43.830](#) and [43.43.842](#) or state or federal findings of abandonment, abuse, neglect or financial exploitation; and

(4) Tuberculosis screening to establish tuberculosis status per this chapter.

WAC 388-76-10198

Adult family homes – Personnel records.

The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

- (1) Staff information such as address and contact information.
- (2) Staff orientation and training records pertinent to duties, including, but not limited to:
 - (a) Training required by chapter [388-112](#) WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;
 - (b) Cardiopulmonary resuscitation;
 - (c) First aid; and
 - (d) HIV/AIDS training.
- (3) Tuberculosis testing results.
- (4) Criminal history disclosure and background check results as required.

WAC 388-76-10265

Tuberculosis—Testing—Required.

- (1) The adult family home must develop and implement a system to ensure the following persons have tuberculosis testing within three days of employment:
 - (a) Provider;
 - (b) Entity representative;
 - (c) Resident manager;
 - (d) Caregiver;
 - (e) Staff; and
 - (f) Any student or volunteer providing any resident care and services.
- (2) For the purposes of the tuberculosis sections "person" means the people listed in this section as required to have tuberculosis testing.

WAC 388-76-10270

Tuberculosis—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).

WAC 388-76-10275

Tuberculosis—No testing

The adult family home is not required to have a person tested for tuberculosis if the person has:

- (1) A documented history of a previous positive skin test, with ten or more millimeters induration;
- (2) A documented history of a previous positive blood test; or
- (3) Documented evidence of:
 - (a) Adequate therapy for active disease; or

(b) Completion of treatment for latent tuberculosis infection preventive therapy.

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.

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.

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.

WAC [388-76-10295](#)

Tuberculosis—Negative test result.

The adult family home may be required by the public health provider or licensing authority to ensure that persons with negative test results have follow-up testing in certain circumstances, such as:

- (1) After exposure to active tuberculosis;
- (2) When tuberculosis symptoms are present; or
- (3) For periodic testing as determined by the health provider.

WAC [388-76-10300](#)

Tuberculosis—Declining a skin test.

The adult family home must ensure that a person take the blood test for tuberculosis if they decline the skin test.

WAC [388-76-10305](#)

Tuberculosis—Reporting required.

The adult family home must:

- (1) Report any person or resident with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider or public health provider;
- (2) Follow the infection control and safety measures ordered by the person's health care provider, including a public health provider; and
- (3) Institute appropriate infection control measures.

WAC [388-76-10310](#)

Tuberculosis – Test records.

The adult family home must:

- (1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the adult family home;
- (2) Make the records readily available to the appropriate health authority and licensing agency;
- (3) Provide the employee a copy of his/her testing results; and
- (4) Retain the records for eighteen months after the date an employee either quits or is terminated.

Assisted Living Facility Licensing Rules.

WAC [388-78A-2206](#)

Respite – Assessment.

The assisted living facility must ensure that any individual on respite has assessments performed, where needed, and if the assessment of the individual shows symptoms of:

- (1) Tuberculosis, follow required tuberculosis testing requirements; and
- (2) Other infectious conditions or diseases, follow the appropriate infection control processes.

WAC [388-78A-2480](#)

Tuberculosis – Testing – Required.

- (1) The assisted living facility must develop and implement a system to ensure each staff person is screened for tuberculosis within three days of employment.
- (2) For purposes of WAC [388-78A-2481](#) through [388-78A-2489](#), "staff person" means any assisted living facility employee or temporary employee of the assisted living facility, excluding volunteers and contractors.

WAC [388-78A-2481](#)

Tuberculosis – Testing method – Required.

The assisted living facility 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).

WAC 388-78A-2482

Tuberculosis – No testing.

The assisted living facility is not required to have a staff person tested for tuberculosis if the staff person has:

- (1) A documented history of a previous positive skin test, with ten or more millimeters induration;
- (2) A documented history of a previous positive blood test; or
- (3) Documented evidence of:
 - (a) Adequate therapy for active disease; or
 - (b) Completion of treatment for latent tuberculosis infection preventive therapy.

WAC 388-78A-2483

Tuberculosis – One test.

The assisted living facility is only required to have a staff person take one test if the staff person has any of the following:

- (1) A documented history of a negative result from a previous two step skin 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.

WAC 388-78A-2484

Tuberculosis – Two step skin testing.

Unless the staff person meets the requirement for having no skin testing or only one test, the assisted living facility choosing to do skin testing, must ensure that each staff 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.

WAC 388-78A-2485

Tuberculosis – Positive test result.

When there is a positive result to tuberculosis skin or blood testing the assisted living facility must:

- (1) Ensure that the staff person has a chest X ray within seven days;
- (2) Ensure each resident or staff person with a positive test result is evaluated for signs and symptoms of tuberculosis; and
- (3) Follow the recommendation of the resident or staff person's health care provider.

WAC 388-78A-2486

Tuberculosis – Negative test result.

The assisted living facility may be required by the public health provider or licensing authority to ensure that staff persons with negative test results have follow-up testing in certain circumstances, such as:

- (1) After exposure to active tuberculosis;
- (2) When tuberculosis symptoms are present; or
- (3) For periodic testing as determined by the public health provider.

WAC 388-78A-2487

Tuberculosis – Declining a skin test.

The assisted living facility must ensure that a staff person take the blood test for tuberculosis if they decline the skin test.

WAC 388-78A-2488

Tuberculosis – Reporting – Required.

The assisted living facility must:

- (1) Report any staff person or resident with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider, or public health provider;
- (2) Follow the infection control and safety measures ordered by the staff person's health care provider including a public health provider;
- (3) Institute appropriate infection control measures;
- (4) Apply living or work restrictions where residents or staff persons are, or may be, infectious and pose a risk to other residents and staff persons; and
- (5) Ensure that staff person's caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in chapter [296-842 WAC](#).

WAC 388-78A-2489

Tuberculosis – Test records.

The assisted living facility must:

- (1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the assisted living facility;
- (2) Make the records readily available to the appropriate health provider and licensing agency,
- (3) Retain the records for at least two years after the date the staff person either quits or is terminated; and
- (4) Provide the staff person a copy of his/her test results.

Nursing Homes.

WAC 388-97-1360

Surveillance, management and early identification of individuals with active tuberculosis.

- (1) The nursing home must develop and implement policies and procedures that comply with nationally recognized tuberculosis standards set by the Centers for Disease Control (CDC), and applicable state law.

Such policies and procedures include, but are not limited to, the following:

- (a) Evaluation of any resident or employee with symptoms suggestive of tuberculosis whether tuberculin skin test results were positive or negative;
 - (b) Identifying and following up residents and personnel with suspected or actual tuberculosis, in a timely manner; and
 - (c) Identifying and following up visitors and volunteers with symptoms suggestive of tuberculosis.
- (2) The nursing home must comply with chapter [49.17](#) RCW, Washington Industrial Safety and Health Act (WISHA) requirements to protect the health and safety of employees.

WAC 388-97-1380

Tuberculosis—Testing required.

- (1) The nursing home must develop and implement a system to ensure that facility personnel and residents have tuberculosis testing within three days of employment or admission.
- (2) The nursing home must also ensure that facility personnel are tested annually.
- (3) For the purposes of WAC [388-97-1360](#) through [388-97-1580](#) "person" means facility personnel and residents.

WAC 388-97-1400

Tuberculosis—Testing method—Required.

The nursing 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).

WAC 388-97-1440

Tuberculosis—No testing.

The nursing home is not required to have a person tested for tuberculosis if the person has:

- (1) A documented history of a previous positive skin test results;
- (2) A documented history of a previous positive blood test; or
- (3) Documented evidence of:
 - (a) Adequate therapy for active disease; or
 - (b) Completion of treatment for latent tuberculosis infection preventive therapy.

WAC 388-97-1460

Tuberculosis—One test.

The nursing 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.

WAC [388-97-1480](#)

Tuberculosis—Two-step skin testing.

Unless the person meets the requirement for having no skin testing or only one test, the nursing 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.

WAC [388-97-1500](#)

Tuberculosis—Positive test result.

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

- (1) Ensure that the person has a chest X ray within seven days;
- (2) Evaluate each resident or person with a positive test result for signs and symptoms of tuberculosis; and
- (3) Follow the recommendation of the person's health care provider.

WAC [388-97-1520](#)

Tuberculosis—Negative test result.

The nursing home may be required by the public health provider or licensing authority to ensure that persons with negative test results have follow-up testing in certain circumstances, such as:

- (1) After exposure to active tuberculosis;
- (2) When tuberculosis symptoms are present; or
- (3) For periodic testing as determined by the health provider.

WAC [388-97-1540](#)

Tuberculosis—Declining a skin test.

The nursing home must ensure that a person take the blood test for tuberculosis if they decline the skin test.

WAC [388-97-1560](#)

Tuberculosis – Reporting – Required.

The nursing home must:

- (1) Report any staff person or resident with tuberculosis symptoms or a positive chest X ray to the appropriate health care provider, or public health provider;
- (2) Follow the infection control and safety measures ordered by the staff person's health care provider including a public health provider;
- (3) Institute appropriate infection control measures;
- (4) Apply living or work restrictions where residents or staff persons are, or may be, infectious and pose a risk to other residents and staff persons; and
- (5) Ensure that staff person's caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection found in chapter [296-842](#) WAC.

WAC 388-97-1580

Tuberculosis – Test records.

The nursing home must:

- (1) Keep the records of tuberculin test results, reports of X-ray findings, and any physician or public health provider orders in the assisted living facility;
- (2) Make the records readily available to the appropriate health provider and licensing agency,
- (3) Retain the records for at least two years after the date the staff person either quits or is terminated; and
- (4) Provide the staff person a copy of his/her test results.

WAC 388-97-1600

Care of residents with active tuberculosis.

(1) When the nursing home accepts the care of a resident with suspected or confirmed tuberculosis, the nursing home must:

- (a) Coordinate the resident's admission, nursing home care, discharge planning, and discharge with the health care provider;
- (b) Provide necessary education about tuberculosis for staff, visitors, and residents; and
- (c) Ensure that personnel caring for a resident with active tuberculosis comply with the WISHA standards for respiratory protection, chapter [296-842 WAC](#).

(2) For a resident who requires respiratory isolation for tuberculosis, the nursing home must:

- (a) Provide a private or semiprivate isolation room:
 - (i) In accordance with [WAC 388-97-2480](#);
 - (ii) In which, construction review of the department of health determines that room air is maintained under negative pressure; and appropriately exhausted, either directly to the outside away from intake vents or through properly designed, installed, and maintained high efficiency particulate air (HEPA) filters, or other measures deemed appropriate to protect others in the facility;
 - (iii) However, when a semiprivate isolation room is used, only residents requiring respiratory isolation for confirmed or suspected tuberculosis are placed together.
- (b) Provide supplemental environment approaches, such as ultraviolet lights, where deemed to be necessary;
- (c) Provide appropriate protective equipment for staff and visitors; and
- (d) Have measures in place for the decontamination of equipment and other items used by the resident.

WAC 388-97-1880

Short-term care, including respite services and adult day or night care.

(1) The nursing home may provide short-term care to individuals which include:

- (a) Respite services to provide relief care for families or other caregivers of individuals with disabilities which must:
 - (i) Provide short-term care and supervision in substitution for the caregiver;
 - (ii) Be for short-term stays up to a maximum of thirty-one days; and
 - (iii) Not be used as a short-term placement pending the individual's admission to the nursing home.
- (b) Adult day or night care to provide short-term nursing home care:
 - (i) Not to exceed sixteen hours each day; and
 - (ii) May be on a regular or intermittent basis.

(2) The nursing home providing respite services, and adult day or night care must:

- (a) Develop and implement policies and procedures consistent with this section;

- (b) Ensure that individuals receiving short-term services under respite or adult day or night care are treated and cared for in accordance with the rights and choices of long-term residents, except for transfer and discharge rights which are provided under the program for short-term services which covers the individual in the nursing home;
 - (c) Have appropriate and adequate staff, space, and equipment to meet the individual's needs without jeopardy to the care of regular residents;
 - (d) Before or at the time of admission, obtain sufficient information to meet the individual's anticipated needs. At a minimum, such information must include:
 - (i) The name, address, and telephone number of the individual's attending physician, and alternate physician if any;
 - (ii) Medical and social history, which may be obtained from a respite care assessment and service plan performed by a case manager designated by an area agency on aging under contract with the department, and mental and physical assessment data; and
 - (iii) Physician's orders for diet, medication and routine care consistent with the individual's status on admission.
 - (e) Ensure the individuals have assessments performed, where needed, and where the assessment of the individual reveals symptoms of tuberculosis, follow tuberculosis testing requirements under WAC [388-97-1360](#) through [388-97-1580](#);
 - (f) With the participation of the individual and, where appropriate, their representative, develop a plan of care to maintain or improve their health and functional status during their stay or care in the nursing home;
 - (g) Provide for the individual to:
 - (i) Bring medications from home in accordance with nursing home policy; and
 - (ii) Self-medicate where determined safe.
 - (h) Promptly report injury, illness, or other adverse change in health condition to the attending physician; and
 - (i) Inquire as to the need for and comply with any request of the individual, or where appropriate, the individual's representative, to secure cash and other valuables brought to the nursing home during the stay/care.
- (3) The nursing home may, in lieu of opening a new record, reopen the individual's clinical record with each period of stay or care up to one year from the previous stay or care, provided the nursing home reviews and updates the recorded information.
- (4) Medicaid certified nursing facilities must complete the state-approved resident assessment instrument, within fourteen days, for any individual whose respite stay exceeds fourteen days.

Emergency Respite Centers.

WAC 388-145-0120

How do I apply for a license?

- (1) To apply for an emergency respite center license, the person or legal entity responsible for the center must send the application form to your licensor at DLR.
- (2) With the application form, you must send the following information:
 - (a) Written verification for each applicant and staff person of completion of:
 - (i) A tuberculosis test or X ray unless you can demonstrate medical reasons prohibiting the test;
 - (ii) First-aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the children in care; and

- (iii) HIV/AIDS and bloodborne pathogens training including infection control standards.
- (b) A completed background check form for each applicant, staff person, board member, intern or volunteer on the premises who:
 - (i) Is at least sixteen years old; and
 - (ii) Has unsupervised access to children (emergency respite centers must comply with chapter [388-06](#) WAC regarding background checks).
- (3) If you, any staff person, board member, intern, or volunteer has lived in Washington state less than three years and will have unsupervised access to children, you must provide us with a completed FBI fingerprint form.

WAC 388-145-0560

What must I do to prevent the spread of infections and communicable diseases?

- (1) You must take precautions to guard against infections and communicable diseases infecting the children under care in an emergency respite center.
- (2) Staff with a reportable communicable disease in an infectious stage, as defined by the department of health, must not be on duty until they have a physician's approval for returning to work.
- (3) Each center that cares for medically fragile children must have an infection control program supervised by a registered nurse.
- (4) Applicants for a license or adults authorized to have unsupervised access to children in a center must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed or licensed unless:
 - (a) The person has evidence of testing within the previous twelve months;
 - (b) The person has evidence that they have a negative chest X ray since previously having a positive skin test;
 - (c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.
- (5) The department does not require a tuberculin skin test if:
 - (a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or
 - (b) A physician indicates that the test is medically inadvisable.
- (6) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.
- (7) The department does not require retesting at the time of license renewal, unless the licensee or staff person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider

WAC 388-147-0070

What is required when completing an application for licensing?

License applications are available from the division of licensed resources, children's administration.

- (1) To apply for a license, the person or legal entity responsible for the facility must include with the application the following:
 - (a) Written verification for all applicant(s), staff, interns, volunteers and individuals who may have unsupervised access to children and youth in care of the following information:
 - (i) A tuberculosis (TB) test or an X ray, unless the individual can demonstrate a religious or a medical reason prohibiting the test;

Note: Written documentation from your physician that indicates you are free of the signs and symptoms of tuberculosis may be accepted for individuals with a religious or a medical prohibition to the TB test.

(ii) First-aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the residents in care; and

(iii) HIV/AIDS and bloodborne pathogens training including infection control standards.

(2) The completed background check forms on anyone on the premises having unsupervised access to children who is at least sixteen years old or older who is not a resident must be sent to the licensor.

Note: See chapter [388-06](#) WAC.

(3) A completed FBI fingerprint form must be completed on a licensee, staff, employee, and any individual having unsupervised access to residents, who has lived outside Washington state within the last three years.

(4) Certificates of compliance from the department of health (DOH) and Washington state patrol fire protection bureau (WSPFPB) demonstrating the facility has met the requirements for health, fire and life safety are required prior to licensing. Both agencies perform inspections of the facility, including apartments, at licensing and relicensing of the facility. Proper notice to apartment residents is required.

WAC 388-147-0380

What steps must be taken to prevent the spread of infections and communicable diseases?

(1) The licensee must take precautions to guard against infections and communicable diseases infecting the children and youth residing at the facility by following the department of health regulations.

(2) Applicants for a license or adults authorized to have unsupervised access to residents at the facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed, volunteering, or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since a previously positive skin test; or

(c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.

(3) The department does not require a tuberculin skin test if:

(a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or

(b) A physician indicates that the test is medically inadvisable.

(4) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.

(5) The department does not require retesting for license renewals unless a person believes he or she has been exposed to someone with tuberculosis or if testing is recommended by his or her health care provider.

(6) The licensee must keep the results of the TB test results in the personnel files available for review by DLR.

Licensing Requirements for Child Foster Homes, Staff Residential Homes, Group Residential Facilities, and Child-Placing Agencies.

WAC 388-148-0050

How do I apply for a license?

License applications are available from the division of licensed resources and licensed child placing agencies.

(1) To apply for a license, the person or legal entity responsible for your home or facility must include with the application the following:

(a) Written verification for each applicant(s), staff, interns, volunteers and individuals who may have unsupervised access to children in care of the following information:

(i) A negative tuberculosis test or an X ray, unless you can demonstrate a religious or a medical reason prohibiting the test;

Note: Written documentation from your physician that indicates you are free of the signs and symptoms of tuberculosis may be accepted for individuals with a religious or a medical prohibition to the TB test.

(ii) First aid and cardio-pulmonary resuscitation (CPR) training appropriate to the age of the children in care; and

(iii) HIV/AIDS and bloodborne pathogens training including infection control standards.

(2) You must send a completed background check form to your licensor on anyone on the premises having unsupervised access to a child who:

(a) Is at least sixteen years old or older;

(b) Is not a foster child; nor an individual eighteen through twenty years old authorized to remain in foster care (see chapter [388-06](#) WAC).

(3) You must send a completed FBI fingerprint form on any individual in your home or facility who has lived outside Washington state within the last three years and meets WAC 388-148-0050 (2)(a)(b).

(4) A group care facility or staffed residential home licensed for six is required to meet the health and fire safety requirements to receive a certificate of compliance from the department of health and the Washington state patrol fire protection bureau.

WAC 388-148-0345

What must I do to prevent the spread of infections and communicable diseases?

You must take precautions to guard against infections and communicable diseases infecting the children under care in your home or facility.

General communicable diseases and infections

(1) In each home or facility, other than a foster home, staff with a reportable communicable disease or notifiable disease condition, as defined by the department of health, in chapter [246-101](#) WAC, in an infectious stage must not be on duty until they have a physician's approval for returning to work.

(2) Each home or facility, other than a foster home, that cares for medically fragile children and children with a severe developmental disability must have an infection control program supervised by a registered nurse.

(3) Foster homes and staffed residential homes licensed for five or fewer children who are medically fragile may use other alternatives, such as in-home nursing services, to consult on infection control procedures.

Tuberculosis

(4) Applicants for a license or adults authorized to have unsupervised access to children in a home or facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test upon being employed or licensed unless:

(a) The person has evidence of testing within the previous twelve months;

(b) The person has evidence that they have a negative chest X ray since a previously positive skin test;

- (c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis.
- (5) The department does not require a tuberculin skin test if:
 - (a) A person has a tuberculosis skin test that has been documented as negative within the past twelve months; or
 - (b) A physician indicates that the test is medically inadvisable.
- (6) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.
- (7) The department does not require retesting for license renewals unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.
- (8) The facility must keep the results of the applicant and employees TB test results in the personnel file available for review by DLR.

WAC 388-148-0541

Excluding respite care, who may provide care to a foster child in the foster home when the foster parent is away from the home?

- (1) Occasionally, and for less than twenty-four hours, the foster parent, at their own expense, may use a friend or a relative as a substitute caregiver in the foster home, without verifying criminal and founded child abuse/neglect history when the foster parent has no reason to suspect the substitute caregiver:
 - (a) Has a criminal or founded child abuse or neglect history that would disqualify them from caring for a department child; or
 - (b) Would be a risk to the foster child while in the substitute's care.
- (2) The foster parent must:
 - (a) Be familiar and comfortable with the individual who will be caring for the foster child;
 - (b) Meet with the substitute caregiver and review the expectations regarding supervision and discipline of the foster child, including the requirement that no physical discipline is used on foster children;
 - (c) Be responsible for providing the caregiver any special care instructions;
 - (d) Provide information on how to be contacted by the substitute caregiver; and
 - (e) Ensure the child has a safety plan.
- (3) If the care by the friend or relative is a regular arrangement, the foster parents must have written approval of the social worker for the arrangement and provide the social worker with evidence from the substitute caregiver of:
 - (a) Current first aid and age-appropriate CPR training;
 - (b) HIV/AIDS and bloodborne pathogens training;
 - (c) A nondisqualifying background check; and
 - (d) A tuberculosis test.

WAC 388-148-0542

May a foster child be supervised by someone under eighteen in the foster home?

- (1) A foster parent, at their own expense, may use a friend or relative who is sixteen or seventeen to supervise (baby sit) a foster child under the following conditions:
 - (a) The foster parent knows the youth babysitter to be reliable and mature enough to provide appropriate care to the foster child.

(b) The youth babysitter has completed a background check within the past year. Exception: For occasional care of less than twenty-four hours, the verification of the background check is not required, as provided in WAC [388-148-0541](#) (1)(a)(b).

(c) The youth babysitter must not be responsible for more than three children.

(2) If the care by the youth babysitter is a regular arrangement, the foster parents must have the written approval of the social worker and provide the social worker with evidence from the youth babysitter of:

(a) Current first aid and age-appropriate CPR training;

(b) HIV/AIDS training including bloodborne pathogens training;

(c) A nondisqualifying background check; and

(d) A tuberculosis test.

Minimum Licensing Requirements for Overnight Youth Shelters.

WAC [388-160-0105](#)

What qualifications must a lead counselor have in order to work in a shelter?

To work in an overnight youth shelter, lead counselors must meet the following qualifications:

(1) Be at least twenty-one years of age;

(2) Have at least one year of experience working with adolescents;

(3) Have completed HIV/AIDS/Bloodborne pathogen training;

(4) Have completed first aid and CPR; and

(5) Have completed a tuberculin test (as required under WAC [388-160-0565](#)).

WAC [388-160-0115](#)

What minimum qualifications must child care staff, lead counselors, interns, and volunteers have in order to work in a shelter?

(1) All child care staff, lead counselors, interns, and volunteers who work at an overnight youth shelter must be at least twenty-one years old. Note: Eighteen through twenty-year-old persons may work or volunteer at an overnight youth shelter if they are enrolled and participating in an internship program through an accredited college or university. They must be on-duty and supervised by a fully trained staff person twenty-one years old or older.

(2) Child care staff, interns, and volunteers also must have successfully completed:

(a) A background check (see chapter [388-06](#) WAC);

(b) A tuberculin test (as required under WAC [388-160-0565](#));

(c) Current first-aid and cardiopulmonary resuscitation (CPR) training; and

(d) HIV/AIDS/Bloodborne pathogen training consistent with the department of health approved curriculum prior to beginning work with youth. If the training is not readily available, it must be completed within sixty days of beginning work.

WAC [388-160-0145](#)

How do I apply or reapply for a license?

(1) To apply or reapply for a license, the person or legal entity responsible for your overnight youth shelter must send the following information to the department licenser:

(a) The application form;

Note: If you are applying for a license renewal, you must send the application form to the department licensor ninety days prior to the expiration of your current license.

(b) A completed and signed criminal history and background inquiry form from each applicant, staff person, intern, board member and volunteer who:

(i) Is at least sixteen years old;

(ii) Is not a foster child or shelter youth; and

(iii) Has unsupervised access to youth.

(c) Written verification of:

(i) A tuberculosis test unless you have religious beliefs which prohibit the test;

(ii) First-aid and cardiopulmonary resuscitation (CPR) training; and

(iii) HIV-AIDS/Bloodborne pathogens training.

(2) If a person required to have a background check has lived in Washington state less than three years immediately prior to their application, a completed FBI fingerprint form must be provided to us for that person.

(3) We may require additional information from you including, but not limited to:

(a) Substance and alcohol abuse evaluations;

(b) Psychiatric evaluations;

(c) Psycho-sexual evaluations; and

(d) Medical evaluations.

WAC 388-160-0315

What personnel records must I keep?

You must keep personnel records on file for each staff person and volunteer for your overnight youth shelter. These must include:

(1) An employment application, including work and education history;

(2) Documentation of completed criminal history and background check form;

(3) A record of a negative Mantoux, tuberculin skin tests results, X ray, or an exemption to the skin test or X ray;

(4) A record of participation in HIV/AIDS education and training, including bloodborne pathogens training;

(5) A record of participation in staff development training;

(6) A record of participation in the program's orientation;

(7) Documentation of a valid food handler permit, when applicable; and

(8) A record of participation in the current first-aid/CPR/Bloodborne pathogens training.

WAC 388-160-0565

What must I do to prevent the spread of infections and communicable diseases?

(1) You must take precautions to guard against infections and communicable diseases infecting the youth in care in your overnight youth shelter.

(2) Staff with a reportable communicable disease, as defined by the department of health, in an infectious stage must not be on duty until the staff has a physician's approval for returning to work.

- (3) Those persons who have been approved for unsupervised access to children in an overnight youth shelter facility must have a tuberculin (TB) skin test by the Mantoux method of testing. They must have this skin test prior to being employed, volunteering, or being licensed unless:
- (a) The person has evidence of testing within the previous twelve months;
 - (b) The person has evidence that they have a negative chest X ray since a previously positive skin test;
 - (c) The person has evidence of having completed adequate preventive therapy or adequate therapy for active tuberculosis; or
 - (d) A physician indicates that the test is medically inadvisable.
- (4) Persons whose tuberculosis skin test is positive must have a chest X ray within thirty days following the skin test.
- (5) The department does not require retesting unless a person believes they have been exposed to someone with tuberculosis or if testing is recommended by their health care provider.

Chemical Dependency Services.

WAC [388-877B-0100](#)

Chemical dependency detoxification services—General.

The rules in WAC 388-877B-0100 through [388-877B-0130](#) apply to behavioral health agencies that provide detoxification services. The definitions in WAC [388-877-0200](#) also apply to chemical dependency detoxification services. The department requires all agencies and providers affected by this rule to fully comply with the applicable requirements in chapter [388-877](#) WAC, chapter 388-877A WAC, chapter [388-877B](#) WAC, and chapter [388-877C](#) WAC no later than September 1, 2013.

- (1) Chemical dependency detoxification services are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, in accordance with patient placement criteria (PPC).
- (2) A behavioral health agency certified for detoxification services may choose to provide optional chemical dependency youth detoxification services (see WAC [388-877B-0130](#)). Optional youth detoxification services require additional program-specific certification by the department's division of behavioral health and recovery (DBHR).
- (3) An agency providing detoxification services to an individual must:
- (a) Be a facility licensed by department of health under one of the following department of health chapters:
 - (i) Hospital licensing regulations (chapter [246-320](#) WAC);
 - (ii) Private psychiatric and alcoholism hospitals (chapter [246-322](#) WAC);
 - (iii) Private alcohol and chemical dependency hospitals (chapter [246-324](#) WAC); or
 - (iv) Residential treatment facility (chapter [246-337](#) WAC);
 - (b) Be licensed by the department as a behavioral health agency;
 - (c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter [388-877](#) WAC, Behavioral health services administrative requirements; and
 - (d) Have policies and procedures to support and implement the:
 - (i) General requirements in chapter [388-877](#) WAC; and
 - (ii) Specific applicable requirements in WAC 388-877B-0100 through [388-877B-0130](#).
- (4) An agency must:**
- (a) Use PPC for admission, continued services, and discharge planning and decisions.
 - (b) Provide counseling to each individual that addresses the individual's:

- (i) Chemical dependency and motivation;
- (ii) Continuing care needs and need for referral to other services.
- (c) Maintain a list of resources and referral options that can be used by staff members to refer an individual to appropriate services.
- (d) Post any rules and responsibilities for individuals receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.
- (e) Provide tuberculosis screenings to individuals for the prevention and control of tuberculosis.
- (f) Provide HIV/AIDS information and include a brief risk intervention and referral as indicated.

WAC [388-877B-0110](#)

Chemical dependency detoxification services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency detoxification services must ensure:

- (1) All chemical dependency assessment and counseling services are provided by a chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor.
- (2) There is a designated clinical supervisor who:
 - (a) Is a CDP;
 - (b) Has documented competency in clinical supervision;
 - (c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP; and
 - (d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW [18.130.180](#).
- (3) Each staff member providing detoxification services to an individual, with the exception of licensed staff members and CDPs, completes a minimum of forty hours of documented training before being assigned individual care duties. **This personnel training must include the following topics:**
 - (i) Chemical dependency;
 - (ii) Infectious diseases, to include hepatitis and tuberculosis (TB); and
 - (iii) Detoxification screening, admission, and signs of trauma.
- (4) Each CDPT has at least one approved supervisor who meets the qualifications in WAC [246-811-049](#). An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.
- (5) Each staff member that provides individual care has a copy of an initial TB screen or test and any subsequent screenings or testing in their personnel file.
- (6) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens, and TB. The training must be documented in the personnel file.

WAC [388-877B-0200](#)

Chemical dependency residential treatment services—General.

The rules in WAC 388-877B-0200 through [388-877B-0280](#) apply to behavioral health agencies that provide chemical dependency residential treatment services. The definitions in WAC [388-877-0200](#) also apply to chemical dependency residential treatment services. The department requires all agencies and providers affected by this rule to fully comply with the applicable requirements in chapter [388-877](#) WAC,

chapter 388-877A WAC, chapter [388-877B](#) WAC, chapter [388-877C](#) WAC no later than September 1, 2013.

(1) Residential treatment services provide chemical dependency treatment for an individual and include room and board in a facility with twenty-four-hours-a-day supervision.

(2) Residential treatment services require additional program-specific certification by the department's division of behavioral health and recovery and include:

- (a) Intensive inpatient services (see WAC [388-877B-0250](#));
- (b) Recovery house treatment services (see WAC [388-877B-0260](#));
- (c) Long-term residential treatment services (see WAC [388-877B-0270](#)); and
- (d) Youth residential services (see WAC [388-877B-0280](#)).

(3) An agency providing residential treatment services must:

(a) Be a facility licensed by department of health (DOH) and meet the criteria under one of the following DOH chapters:

- (i) Hospital licensing regulations (chapter [246-320](#) WAC);
- (ii) Private psychiatric and alcoholism hospitals (chapter [246-322](#) WAC);
- (iii) Private alcohol and chemical dependency hospitals (chapter [246-324](#) WAC); or
- (iv) Residential treatment facility (chapter [246-337](#) WAC);

(b) Be licensed by the department as a behavioral health agency;

(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter [388-877](#) WAC, Behavioral health services administrative requirements; and

(d) Have policies and procedures to support and implement the:

- (i) General requirements in chapter [388-877](#) WAC; and
- (ii) Specific applicable requirements in WAC 388-877B-0200 through [388-877B-0280](#).

(4) An agency must:

(a) Use patient placement criteria (PPC) for admission, continued services, and discharge planning and decisions.

(b) Provide education to each individual admitted to the treatment facility on:

- (i) Alcohol, other drugs, and/or chemical dependency;
- (ii) Relapse prevention;
- (iii) Blood borne pathogens; and

(iv) Tuberculosis (TB).

(c) Provide education or information to each individual admitted on:

- (i) Emotional, physical, and sexual abuse;
- (ii) Nicotine addiction; and
- (iii) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy.

(d) Maintain a list or source of resources, including self-help groups, and referral options that can be used by staff to refer an individual to appropriate services.

(e) Screen for the prevention and control of tuberculosis.

(f) Limit the size of group counseling sessions to no more than twelve individuals.

(g) Have written procedures for:

- (i) Urinalysis and drug testing, including laboratory testing; and
- (ii) How agency staff members respond to medical and psychiatric emergencies.

(5) An agency that provides services to a pregnant woman must:

(a) Have a written procedure to address specific issues regarding the woman's pregnancy and prenatal care needs; and

(b) Provide referral information to applicable resources.

(6) An agency that provides an assessment to an individual under RCW [46.61.5056](#) must also meet the requirements for driving under the influence (DUI) assessment providers in WAC 388-877B-0550.

WAC [388-877B-0210](#)

Chemical dependency residential treatment services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency residential treatment services must ensure all chemical dependency assessment and counseling services are provided by a chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor.

The agency must ensure:

(1) There is a designated clinical supervisor who:

(a) Is a CDP;

(b) Has documented competency in clinical supervision;

(c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. The monitoring must include a semi-annual review of a sample of the clinical records maintained by the CDP; and

(d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW [18.130.180](#).

(2) Each CDPT has at least one approved supervisor who meets the qualifications in WAC [246-811-049](#). An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.

(3) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens and tuberculosis (TB) and the training is documented in each personnel file.

(4) Each staff member that provides individual care has a copy of an initial TB screen or test and any subsequent screening or testing in their personnel file.

WAC [388-877B-0220](#)

Chemical dependency residential treatment services—Clinical record content and documentation requirements.

In addition to the general clinical record content requirements in WAC 388-877-0640, an agency providing chemical dependency residential treatment services must maintain an individual's clinical record.

(1) The clinical record must contain:

(a) Documentation the individual was informed of the federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.

(b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanction.

(c) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.

(d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur, or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.

(e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:

(i) The individual's demographic information; and

(ii) The diagnostic assessment statement and other assessment information to include:

(A) Documentation of the HIV/AIDS intervention.

(B) Tuberculosis (TB) screen or test result.

(C) A record of the individual's detoxification and treatment history.

(D) The reason for the individual's transfer.

(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.

(F) A discharge summary and continuing care plan.

(f) Documentation that a staff member(s) met with each individual at the time of discharge, unless the individual left without notice, to:

(i) Determine the appropriate recommendation for care and finalize a continuing care plan.

(ii) Assist the individual in making contact with necessary agencies or services.

(iii) Provide and document the individual was provided with a copy of the plan.

(g) Documentation that the discharge summary was completed within seven working days of the individual's discharge from the agency, which includes the date of discharge and a summary of the individual's progress toward each individual service plan goal.

(2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:

(a) Be personalized to the individual's unique treatment needs.

(b) Be initiated with at least one goal identified by the individual during the initial assessment or at the first service session following the assessment.

(c) Include individual needs identified in the diagnostic and periodic reviews, addressing:

(i) All substance use needing treatment, including tobacco, if necessary;

(ii) Patient bio-psychosocial problems;

(iii) Treatment goals;

(iv) Estimated dates or conditions for completion of each treatment goal; and

(v) Approaches to resolve the problem.

(d) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.

(e) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.

(f) Document that the plan has been reviewed with the individual.

WAC [388-877B-0300](#)

Chemical dependency outpatient treatment services—General.

The rules in WAC 388-877B-0300 through [388-877B-0370](#) apply to behavioral health agencies that provide chemical dependency outpatient treatment services. The definitions in WAC [388-877-0200](#) also apply to chemical dependency outpatient treatment services. The department requires all agencies and providers affected by this rule to fully comply with the applicable requirements in chapter [388-877](#) WAC, chapter 388-877A WAC, chapter [388-877B](#) WAC, and chapter [388-877C](#) WAC no later than September 1, 2013.

- (1) Outpatient treatment services provide chemical dependency treatment to an individual and include essential education and counseling services in accordance with patient placement criteria (PPC).
- (2) Chemical dependency outpatient treatment services require additional program-specific certification by the department's division of behavioral health and recovery and include:
 - (a) Level II intensive outpatient treatment services (see WAC [388-877B-0350](#)); and
 - (b) Level I outpatient treatment services (see WAC [388-877B-0360](#)).
- (3) An agency providing outpatient treatment services to an individual must:
 - (a) Be licensed by the department as a behavioral health agency;
 - (b) Meet the applicable behavioral health agency licensure, certification, administration, personnel, and clinical requirements in chapter [388-877](#) WAC, Behavioral health services administrative requirements; and
 - (c) Have policies and procedures to support and implement the:
 - (i) General requirements in chapter [388-877](#) WAC; and
 - (ii) Specific applicable requirements in WAC 388-877B-0300 through [388-877B-0370](#).
- (4) An agency must:**
 - (a) Use the PPC for admission, continued services, and discharge planning and decisions.
 - (b) Have an outline of each lecture and education session included in the service, sufficient in detail for another trained staff member to deliver the session in the absence of the regular instructor.
 - (c) Maintain a list of resources, including self-help groups, and referral options that can be used by staff members to refer an individual to appropriate services.
 - (d) Provide tuberculosis screenings to individuals for the prevention and control of tuberculosis.**
- (5) An agency must:**
 - (a) Provide education to each individual admitted to the treatment facility on:**
 - (i) Alcohol, other drugs, and/or chemical dependency;
 - (ii) Relapse prevention;
 - (iii) Blood borne pathogens; and
 - (iv) Tuberculosis (TB).**
 - (b) Provide education or information to each individual admitted on:
 - (i) Emotional, physical, and sexual abuse;
 - (ii) Nicotine addiction; and
 - (iii) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy.
 - (c) Limit the size of group counseling sessions to no more than twelve individuals.
 - (d) Have written procedures for:
 - (i) Urinalysis and drug testing, including laboratory testing; and
 - (ii) How agency staff members respond to medical and psychiatric emergencies.
- (6) An agency that provides services to a pregnant woman must:
 - (a) Have a written procedure to address specific issues regarding a woman's pregnancy and prenatal care needs; and
 - (b) Provide referral information to applicable resources.
- (7) An agency that provides youth outpatient treatment services must:
 - (a) Have a written procedure to assess and refer an individual to the department's child welfare services when applicable; and
 - (b) Ensure that counseling sessions with nine to twelve youths include a second adult staff member.
- (8) An agency that provides a DUI assessment to an individual under RCW [46.61.5056](#) must also be certified by the department under WAC [388-877B-0550](#).
- (9) An agency must ensure that when offering off-site treatment:
 - (a) The agency maintains a current list of all locations where off-site services are provided, including:

- (i) The name and address (except for an individual receiving in-home services);
- (ii) The primary purpose of the off-site location;
- (iii) The level of services provided; and
- (iv) The date the off-site services began at that location.
- (b) The agency maintains a written procedure of:
 - (i) How confidentiality will be maintained at each off-site location, including how confidential information and individual records will be transported between the certified facility and the off-site location; and
 - (ii) How services will be offered in a manner that promotes individual and agency staff safety.
- (c) The agency is certified to provide the type of service offered at its main location.
- (d) Chemical dependency assessment or treatment is not the primary purpose of the location where the individual is served (such as in a school, hospital, or correctional facility).
- (e) Services are provided in a private, confidential setting within the off-site location.
- (10) Minimum treatment requirements for deferred prosecution are established in chapter [10.05](#) RCW

WAC [388-877B-0310](#)

Chemical dependency outpatient treatment services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency outpatient treatment services must ensure:

- (1) All chemical dependency assessment and counseling services are provided by a chemical dependency professional (CDP), or a department of health-credential CDP trainee (CDPT) under the supervision of an approved supervisor.
- (2) There is a designated clinical supervisor who:
 - (a) Is a CDP;
 - (b) Has documented competency in clinical supervision;
 - (c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP; and
 - (d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW [18.130.180](#).
- (4) Each chemical dependency professional trainee has at least one approved supervisor who meets the qualifications in WAC [246-811-049](#). An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.
- (5) Each staff member that provides individual care has a copy of an initial TB screen or test and any subsequent screenings or testing in their personnel file.
- (6) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens and TB, and document the training in the personnel file.

WAC [388-877B-0320](#)

Chemical dependency outpatient treatment services—Clinical record content and documentation.

- (1) The clinical record must contain:

- (a) Documentation the individual was informed of federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.
- (b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanctions.
- (c) Documentation that the initial individual service plan was completed before treatment services are received.
- (d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.
- (e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:
 - (i) The individual's demographic information; and
 - (ii) The diagnostic assessment statement and other assessment information to include:
 - (A) Documentation of the HIV/AIDS intervention.
 - (B) Tuberculosis (TB) screen or test result.

WAC 388-877B-0320

Chemical dependency outpatient treatment services – Clinical record content and documentation.

In addition to the general clinical record content requirements in WAC 388-877-0640, an agency providing chemical dependency outpatient treatment services must maintain an individual's clinical record.

- (1) The clinical record must contain:
 - (a) Documentation the individual was informed of federal confidentiality requirements and received a copy of the individual notice required under 42 C.F.R. Part 2.
 - (b) Documentation that the individual received a copy of the rules and responsibilities for treatment participants, including the potential use of interventions or sanctions.
 - (c) Documentation that the initial individual service plan was completed before treatment services are received.
 - (d) Documentation of progress notes in a timely manner and before any subsequent scheduled appointments of the same type of service session or group type occur or documentation as to why this did not occur. Progress notes must include the date, time, duration, participant names, and a brief summary of the session and the name of the staff member who provided it.
 - (e) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:
 - (i) The individual's demographic information; and
 - (ii) The diagnostic assessment statement and other assessment information to include:
 - (A) Documentation of the HIV/AIDS intervention.
 - (B) Tuberculosis (TB) screen or test result.
 - (C) A record of the individual's detoxification and treatment history.
 - (D) The reason for the individual's transfer.
 - (E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.
 - (F) A discharge summary and continuing care plan.

- (f) Justification for the change in the level of care when transferring an individual from one certified treatment service to another within the same agency, at the same location.
- (g) Documentation that staff members met with each individual at the time of discharge, unless the individual left without notice, to:
 - (i) Determine the appropriate recommendation for care and finalize a continuing care plan.
 - (ii) Assist the individual in making contact with necessary agencies or services.
 - (iii) Provide and document the individual was provided with a copy of the plan.
- (h) Documentation that a discharge summary was completed within seven days of the individual's discharge, including the date of discharge, a summary of the individual's progress towards each individual service plan goal, legal status, and if applicable, current prescribed medication.
- (2) In addition to the requirements in (1) of this section, an agency must ensure the following for each individual service plan. The individual service plan must:
 - (a) Be personalized to the individual's unique treatment needs;
 - (b) Include individual needs identified in the diagnostic and periodic reviews, addressing:
 - (i) All substance use needing treatment, including tobacco, if necessary;
 - (ii) The individual's bio-psychosocial problems;
 - (iii) Treatment goals;
 - (iv) Estimated dates or conditions for completion of each treatment goal; and
 - (v) Approaches to resolve the problem.
 - (c) Document approval by a chemical dependency professional (CDP) if the staff member developing the plan is not a CDP.
 - (d) Document that the plan was updated to reflect any changes in the individual's treatment needs, or as requested by the individual, at least once per month for the first three months, and at least quarterly thereafter.
 - (e) Document that the plan has been reviewed with the individual.

WAC 388-877B-0400

Chemical dependency opiate substitution treatment services—General.

The rules in WAC 388-877B-0400 through WAC [388-877B-0450](#) apply to behavioral health agencies that provide chemical dependency opiate substitution treatment services. The definitions in WAC [388-877-0200](#) also apply to chemical dependency opiate substitution treatment services. The department requires all agencies and providers affected by this rule to fully comply with the applicable requirements in chapter [388-877](#) WAC, chapter 388-877A WAC, chapter [388-877B](#) WAC, and chapter [388-877C](#) WAC no later than September 1, 2013.

- (1) Opiate substitution treatment services include the dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. These services include detoxification treatment and maintenance treatment.
- (2) An agency must meet all the certification requirements in WAC [388-877B-0405](#) in order to provide opiate substitution treatment services and:
 - (a) Be licensed by the department as a behavioral health agency;
 - (b) Meet the applicable behavioral health agency licensure, certification, administrative, personnel, and clinical requirements in chapter [388-877](#) WAC, Behavioral health services administrative requirements; and
 - (c) Have policies and procedures to support and implement the:
 - (i) General requirements in chapter [388-877](#) WAC; and

- (ii) Program-specific requirements in WAC 388-877B-0400 through [388-877B-0450](#).
- (3) An agency providing opiate substitution treatment services must ensure that the agency's individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.
- (4) An agency must:**
 - (a) Use patient placement criteria (PPC) for admission, continued services, and discharge planning and decisions.
 - (b) Provide education to each individual admitted, totaling no more than fifty percent of treatment services, on:**
 - (i) Alcohol, other drugs, and chemical dependency;
 - (ii) Relapse prevention;
 - (iii) Blood borne pathogens; and
 - (iv) Tuberculosis (TB).**
 - (c) Provide education or information to each individual on:
 - (i) Emotional, physical, and sexual abuse;
 - (ii) Nicotine addiction;
 - (iii) The impact of chemical use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of chemical use during pregnancy; and
 - (iv) Family planning.
 - (d) Have written procedures for:
 - (i) Diversion control that contains specific measures to reduce the possibility of the diversion of controlled substances from legitimate treatment use, and assign specific responsibility to the medical and administrative staff members for carrying out the described diversion control measures and functions.
 - (ii) Urinalysis and drug testing, to include obtaining:
 - (A) Specimen samples from each individual, at least eight times within twelve consecutive months.
 - (B) Random samples, without notice to the individual.
 - (C) Samples in a therapeutic manner that minimizes falsification.
 - (D) Observed samples, when clinically appropriate.
 - (E) Samples handled through proper chain of custody techniques.
 - (iii) Laboratory testing.
 - (iv) The response to medical and psychiatric emergencies.
 - (v) Verifying the identity of an individual receiving treatment services, including maintaining a file in the dispensary with a photograph of the individual and updating the photographs when the individual's physical appearance changes significantly.
- (5) An agency must ensure that an individual is not admitted to opiate substitution treatment detoxification services more than two times in a twelve-month period following admission to services.
- (6) An agency providing services to a pregnant woman must have a written procedure to address specific issues regarding their pregnancy and prenatal care needs, and to provide referral information to applicable resources.
- (7) An agency providing youth opiate substitution treatment services must:
 - (a) Have a written procedure to assess and refer the youth to the department's child welfare services, when applicable.
 - (b) Ensure that a group counseling session with nine to twelve youths include a second staff member.
 - (c) Ensure that before admission the youth has had two documented attempts at short-term detoxification or drug-free treatment within a twelve-month period, with a waiting period of no less than seven days between the first and second short-term detoxification treatment.

- (d) Ensure that when a youth is admitted for maintenance treatment, written consent by a parent or if applicable, legal guardian or responsible adult designated by the relevant state authority, is obtained.
- (8) An agency providing opiate substitution treatment services must ensure:
 - (a) That notification to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the department is made within three weeks of any replacement or other change in the status of the program, program sponsor (as defined in 42 C.F.R. Part 8), or medical director.
 - (b) Treatment is provided to an individual in compliance with 42 C.F.R. Part 8.
 - (c) The number of individuals receiving treatment services does not exceed three hundred fifty unless authorized by the county, city, or tribal legislative authority in which the program is located.
 - (d) The individual record system complies with all federal and state reporting requirements relevant to opioid drugs approved for use in treatment of opioid addiction.
 - (e) The death of an individual enrolled in opiate substitution treatment is reported to the department within one business day.

WAC [388-877B-0410](#)

Chemical dependency opiate substitution treatment services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency opiate substitution treatment services must:

- (1) Appoint a program sponsor, as defined in 42 C.F.R. Part 8, who is responsible for notifying the federal Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), the federal Drug Enforcement Administration (DEA), the department, and the Washington State board of pharmacy of any theft or significant loss of a controlled substance.
- (2) Ensure there is an appointed medical director who:
 - (a) Is licensed by department of health (DOH) to practice medicine and practices within their scope of practice.
 - (b) Is responsible for all medical services performed. See the program physician responsibilities in WAC [388-877B-0440](#).
 - (c) Ensures all medical services provided are in compliance with applicable federal, state, and local rules and laws.
- (3) Ensure all medical services provided are provided by an appropriate DOH-credentialed medical provider practicing within their scope of practice.
- (4) Ensure all chemical dependency assessment and counseling services are provided by a DOH-credentialed chemical dependency professional (CDP), or a CDP trainee (CDPT) under the supervision of an approved supervisor.
- (5) Ensure there is a designated and identified clinical supervisor who:
 - (a) Is a CDP.
 - (b) Has documented competency in clinical supervision.
 - (c) Is responsible for monitoring the continued competency of each CDP in assessment, treatment, continuing care, transfer, and discharge. This monitoring must include a semi-annual review of a sample of each CDP's clinical records.
 - (d) Has not committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under RCW [18.130.180](#).
- (6) Ensure an agency using CDPTs has at least one approved supervisor that meets the qualification in WAC [246-811-049](#). An approved supervisor must decrease the hours of individual contact by twenty percent for each full-time CDPT supervised.

- (7) Ensure at least one staff member has documented training in:
 - (a) Family planning;
 - (b) Prenatal health care; and
 - (c) Parenting skills.
- (8) Ensure that at least one staff member is on duty at all times who has documented training in:
 - (a) Cardiopulmonary resuscitation (CPR); and
 - (b) Management of opiate overdose.
- (9) Ensure that a personnel file for a staff member providing individual care includes a copy of an initial tuberculosis (TB) screen and subsequent screening as appropriate.
- (10) Provide and ensure all staff members receive annual training on:
 - (a) The prevention and control of communicable disease, blood borne pathogens, and TB; and
 - (b) Opiate dependency clinical and medical best practice, specific to the staff member's scope of practice and job function.

WAC [388-877B-0500](#)

Chemical dependency opiate substitution treatment services—General.

The rules in WAC 388-877B-0500 through [388-877B-0550](#) apply to behavioral health agencies that provide chemical dependency assessment services. The definitions in WAC [388-877-0200](#) also apply to chemical dependency assessment services. The department requires all agencies and providers affected by this rule to fully comply with the applicable requirements in chapter [388-877](#) WAC, chapter 388-877A WAC, chapter [388-877B](#) WAC, and chapter [388-877C](#) WAC no later than September 1, 2013.

- (1) Chemical dependency assessment services are provided to an individual to determine the individual's involvement with alcohol and other drugs and determine the appropriate course of care or referral.
- (2) Chemical dependency assessment services include:
 - (a) Assessment only services; and
 - (b) Driving under the influence (DUI) assessment services.
- (3) A behavioral health agency certified for assessment only services may choose to provide optional program-specific DUI assessment services (see WAC [388-877B-0550](#)). Optional DUI assessment services require additional program-specific certification by the department's division of behavioral health and recovery.
- (4) An agency providing assessment services to an individual must:
 - (a) Be licensed by the department as a behavioral health agency;
 - (b) Meet the applicable behavioral health agency licensure, certification, administrative, personnel, and clinical requirements in chapter [388-877](#) WAC, Behavioral health services administrative requirements; and
 - (c) Have policies and procedures to support and implement the:
 - (i) General requirements in chapter [388-877](#) WAC; and
 - (ii) Program-specific requirements in WAC 388-877B-0500 through [388-877B-0550](#).
- (5) An agency providing assessment services:
 - (a) Must review, evaluate, and document information provided by the individual;
 - (b) May include information from external sources such as family, support individuals, legal entities, courts, and employers; and
 - (c) Is not required to meet the individual service plan requirements in WAC [388-877-0620](#).
- (6) An agency must maintain and provide a list of resources, including self-help groups, and referral options that can be used by staff members to refer an individual to appropriate services.

(7) When an individual is transferring to another service provider, documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider to include:

(i) The individual's demographic information; and

(ii) The diagnostic assessment statement and other assessment information to include:

(A) Documentation of the HIV/AIDS intervention.

(B) Tuberculosis (TB) screen or test result.

(C) A record of the individual's detoxification and treatment history.

(D) The reason for the individual's transfer.

(E) Court mandated, department of correction supervision status or the agency's recommended follow-up treatment.

(F) A discharge summary and continuing care plan.

(8) An agency providing driving under the influence (DUI) assessment services must meet the additional program-specific standards in WAC 388-877B-0550.

(9) An agency that offers off-site assessment services must meet the requirements in WAC 388-877B-0300(9).

WAC 388-877B-0510

Chemical dependency assessment only services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency assessment services must ensure:

(1) All chemical dependency assessment only services are provided by a chemical dependency professional (CDP).

(2) There is a designated clinical supervisor who:

(a) Is a CDP;

(b) Has documented competency in clinical supervision; and

(c) Is responsible for monitoring the continued competency of each CDP. The monitoring must include a semi-annual review of a sample of the clinical records kept by the CDP.

(3) Each staff member that provides individual care has a copy of an initial tuberculosis (TB) screen or test and any subsequent screening or testing in their personnel file.

(4) All staff members are provided annual training on the prevention and control of communicable disease, blood borne pathogens, and TB. The training must be documented in the personnel file.

WAC 388-877B-0610

Chemical dependency information and assistance services—Agency staff requirements.

In addition to meeting the agency administrative and personnel requirements in WAC [388-877-0400](#) through [388-877-0530](#), an agency providing chemical dependency information and assistance services must ensure each staff member:

(1) Is provided annual training on the prevention and control of communicable disease, blood borne pathogens and tuberculosis (TB). The training must be documented in the personnel file.

(2) Who provides individual care has a copy of their initial TB screen or test and any subsequent screening or testing in their personnel file.

Superintendent of Public Instruction

Rules for the Provision of Special Education.

WAC [392-172A-01035](#)

Child with a disability or student eligible for special education.

(1)(a) Child with a disability or as used in this chapter, a student eligible for special education means a student who has been evaluated and determined to need special education because of having a disability in one of the following eligibility categories: Intellectual disability, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), an emotional behavioral disability, an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, multiple disabilities, or for students, three through eight, a developmental delay and who, because of the disability and adverse educational impact, has unique needs that cannot be addressed exclusively through education in general education classes with or without individual accommodations, and needs special education and related services.

(b) For purposes of providing a student with procedural safeguard protections identified in WAC [392-172A-05015](#), the term, "student eligible for special education" also includes a student whose identification, evaluation or placement is at issue.

(c) If it is determined, through an appropriate evaluation, that a student has one of the disabilities identified in subsection (1)(a) of this section, but only needs a related service and not special education, the student is not a student eligible for special education under this chapter. School districts and other public agencies must be aware that they have obligations under other federal and state civil rights laws and rules, including 29 U.S.C. 764, RCW [49.60.030](#), and 43 U.S.C. 12101 that apply to students who have a disability regardless of the student's eligibility for special education and related services.

(d) Speech and language pathology, audiology, physical therapy, and occupational therapy services, may be provided as specially designed instruction, if the student requires those therapies as specially designed instruction, and meets the eligibility requirements which include a disability, adverse educational impact and need for specially designed instruction. They are provided as a related service under WAC [392-172A-01155](#) when the service is required to allow the student to benefit from specially designed instruction.

(2) The terms used in subsection (1)(a) of this section are defined as follows:

(a)(i) Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a student's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences.

(ii) Autism does not apply if a student's educational performance is adversely affected primarily because the student has an emotional behavioral disability, as defined in subsection (2)(e) of this section.

(iii) A student who manifests the characteristics of autism after age three could be identified as having autism if the criteria in (a)(i) of this subsection are satisfied.

(b) Deaf-blindness means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for students with deafness or students with blindness and adversely affect a student's educational performance.

(c) Deafness means a hearing impairment that is so severe that the student is impaired in processing linguistic information through hearing, with or without amplification, that adversely affects a student's educational performance.

(d)(i) Developmental delay means a student three through eight who is experiencing developmental delays that adversely affect the student's educational performance in one or more of the following areas: Physical development, cognitive development, communication development, social or emotional development or adaptive development and who demonstrates a delay on a standardized norm referenced test, with a test-retest or split-half reliability of .80 that is at least:

(A) Two standard deviations below the mean in one or more of the five developmental areas; or

(B) One and one-half standard deviations below the mean in two or more of the five developmental areas.

(ii) The five developmental areas for students with a developmental delay are:

(A) Cognitive development: Comprehending, remembering, and making sense out of one's experience. Cognitive ability is the ability to think and is often thought of in terms of intelligence;

(B) Communication development: The ability to effectively use or understand age-appropriate language, including vocabulary, grammar, and speech sounds;

(C) Physical development: Fine and/or gross motor skills requiring precise, coordinated, use of small muscles and/or motor skills used for body control such as standing, walking, balance, and climbing;

(D) Social or emotional development: The ability to develop and maintain functional interpersonal relationships and to exhibit age appropriate social and emotional behaviors; and

(E) Adaptive development: The ability to develop and exhibit age-appropriate self-help skills, including independent feeding, toileting, personal hygiene and dressing skills.

(iii) A school district is not required to adopt and use the category "developmentally delayed" for students, three through eight.

(iv) If a school district uses the category "developmentally delayed," the district must conform to both the definition and age range of three through eight, established under this section.

(v) School districts using the category "developmentally delayed," for students three through eight may also use any other eligibility category.

(vi) Students who qualify under the developmental delay eligibility category must be reevaluated before age nine and determined eligible for services under one of the other eligibility categories.

(vii) The term "developmentally delayed, birth to three years" are those infants and toddlers under three years of age who:

(A) Meet the eligibility criteria established by the state lead agency under Part C of IDEA; and

(B) Are in need of early intervention services under Part C of IDEA. Infants and toddlers who qualify for early intervention services must be evaluated prior to age three in order to determine eligibility for special education and related services.

(e)(i) Emotional/behavioral disability means a condition where the student exhibits one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a student's educational performance:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) Emotional/behavioral disability includes schizophrenia. The term does not apply to students who are socially maladjusted, unless it is determined that they have an emotional disturbance under (e)(i) of this subsection.

(f) Hearing impairment means an impairment in hearing, whether permanent or fluctuating, that adversely affects a student's educational performance but that is not included under the definition of deafness in this section.

(g) Intellectual disability means significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifested during the developmental period, that adversely affects a student's educational performance.

(h) Multiple disabilities means concomitant impairments, the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments. The term, multiple disabilities does not include deaf-blindness.

(i) Orthopedic impairment means a severe orthopedic impairment that adversely affects a student's educational performance. The term includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

(j) Other health impairment means having limited strength, vitality, or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that:

(i) Is due to chronic or acute health problems such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and

(ii) Adversely affects a student's educational performance.

(k)(i) Specific learning disability means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia, that adversely affects a student's educational performance.

(ii) Specific learning disability does not include learning problems that are primarily the result of visual, hearing, or motor disabilities, of intellectual disability, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

(l) Speech or language impairment means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a student's educational performance.

(m) Traumatic brain injury means an acquired injury to the brain caused by an external physical force, resulting in total or partial functional disability or psychosocial impairment, or both, that adversely affects a student's educational performance. Traumatic brain injury applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech. Traumatic brain injury does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

(n) Visual impairment including blindness means an impairment in vision that, even with correction, adversely affects a student's educational performance. The term includes both partial sight and blindness.

Department of Retirement Systems

Law Enforcement Officers' and firefighters' Retirement System.

WAC [415-104-615](#)

Neck.

The following conditions of the neck are causes for rejection of membership:

- (1) **Cervical ribs** if symptomatic, or so obvious that they are found on routine physical examination. (Detection based primarily on X ray is not considered to meet this criterion);
- (2) Congenital cysts of branchial cleft origin or those developing from the remnants of the thyroglossal duct, with or without fistulous tracts;
- (3) **Fistula**, chronic draining, of any type;
- (4) **Healed tuberculosis lymph nodes when extensive in number or densely calcified;**
- (5) **Nonspastic contraction** of the muscles of the neck or cicatricial contracture of the neck to the extent that it interferes with the wearing of a uniform or equipment or is so disfiguring as to make the individual objectionable in common social relationships;
- (6) **Spastic contraction** of the muscles of the neck, persistent, and chronic;
- (7) **Tumor of thyroid or other structures of the neck**, see WAC [415-104-720](#) and [415-104-725](#).

RCW

Department of Health

State Government—Executive

RCW [43.70.080](#)

Transfer of powers and duties from the department of social and health services.

The powers and duties of the department of social and health services and the secretary of social and health services under the following statutes are hereby transferred to the department of health and the secretary of health: Chapters 16.70, 18.20, 18.46, 18.71, 18.73, 18.76, 69.30, 70.28, 70.30, *70.32, *70.33, 70.50, 70.58, 70.62, 70.83, **70.83B, 70.90, 70.98, 70.104, 70.116, 70.118, 70.119, 70.119A, 70.121, 70.127, 70.142, and [80.50](#) RCW. **More specifically, the following programs and services presently administered by the department of social and health services are hereby transferred to the department of health:**

- (1) **Personal health and protection programs and related management and support services, including, but not limited to: Immunizations; tuberculosis; sexually transmitted diseases; AIDS; diabetes control; primary health care; cardiovascular risk reduction; kidney disease; regional genetic services; newborn metabolic screening; sentinel birth defects; cytogenetics; communicable disease epidemiology; and chronic disease epidemiology;**
- (2) **Environmental health protection services and related management and support services, including, but not limited to: Radiation, including X-ray control, radioactive materials, uranium mills, low-level waste, emergency response and reactor safety, and environmental radiation protection; drinking water; toxic substances; on-site sewage; recreational water contact facilities; food services sanitation; shellfish; and general environmental health services, including schools, vectors, parks, and camps;**
- (3) **Public health laboratory;**
- (4) **Public health support services, including, but not limited to: Vital records; health data; local public health services support; and health education and information;**
- (5) **Licensing and certification services including, but not limited to: Health and personal care facility survey, construction review, emergency medical services, laboratory quality assurance, and accommodations surveys; and**
- (6) **Effective January 1, 1991, parent and child health services and related management support services, including, but not limited to: Maternal and infant health; child health; parental health; nutrition;**

handicapped children's services; family planning; adolescent pregnancy services; high priority infant tracking; early intervention; parenting education; prenatal regionalization; and power and duties under RCW 43.20A.635. The director of the office of financial management may recommend to the legislature a delay in this transfer, if it is determined that this time frame is not adequate.

RCW 43.70.520

Public health services improvement plan—Performance measures.

(1) The legislature finds that the public health functions of community assessment, policy development, and assurance of service delivery are essential elements in achieving the objectives of health reform in Washington state. The legislature further finds that the population-based services provided by state and local health departments are cost-effective and are a critical strategy for the long-term containment of health care costs. The legislature further finds that the public health system in the state lacks the capacity to fulfill these functions consistent with the needs of a reformed health care system. The legislature further finds that public health nurses and nursing services are an essential part of our public health system, delivering evidence-based care and providing core services including prevention of illness, injury, or disability; the promotion of health; and maintenance of the health of populations.

(2) The department of health shall develop, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health service, and other state agencies, health services providers, and citizens concerned about public health, a public health services improvement plan. The plan shall provide a detailed accounting of deficits in the core functions of assessment, policy development, assurance of the current public health system, how additional public health funding would be used, and describe the benefits expected from expanded expenditures.

(3) The plan shall include:

(a) Definition of minimum standards for public health protection through assessment, policy development, and assurances:

(i) Enumeration of communities not meeting those standards;

(ii) A budget and staffing plan for bringing all communities up to minimum standards;

(iii) An analysis of the costs and benefits expected from adopting minimum public health standards for assessment, policy development, and assurances;

(b) Recommended strategies and a schedule for improving public health programs throughout the state, including:

(i) Strategies for transferring personal health care services from the public health system, into the uniform benefits package where feasible; and

(ii) Linking funding for public health services to performance measures that relate to achieving improved health outcomes; and

(c) A recommended level of dedicated funding for public health services to be expressed in terms of a percentage of total health service expenditures in the state or a set per person amount; such recommendation shall also include methods to ensure that such funding does not supplant existing federal, state, and local funds received by local health departments, and methods of distributing funds among local health departments.

(4) The department shall coordinate this planning process with the study activities required in section 258, chapter 492, Laws of 1993.

(5) By March 1, 1994, the department shall provide initial recommendations of the public health services improvement plan to the legislature regarding minimum public health standards, and public health programs needed to address urgent needs, such as those cited in subsection (7) of this section.

(6) By December 1, 1994, the department shall present the public health services improvement plan to

the legislature, with specific recommendations for each element of the plan to be implemented over the period from 1995 through 1997.

(7) Thereafter, the department shall update the public health services improvement plan for presentation to the legislature prior to the beginning of a new biennium.

(8) Among the specific population-based public health activities to be considered in the public health services improvement plan are: Health data assessment and chronic and infectious disease surveillance; rapid response to outbreaks of communicable disease; efforts to prevent and control specific communicable diseases, such as tuberculosis and acquired immune deficiency syndrome; health education to promote healthy behaviors and to reduce the prevalence of chronic disease, such as those linked to the use of tobacco; access to primary care in coordination with existing community and migrant health clinics and other not for profit health care organizations; programs to ensure children are born as healthy as possible and they receive immunizations and adequate nutrition; efforts to prevent intentional and unintentional injury; programs to ensure the safety of drinking water and food supplies; poison control; trauma services; and other activities that have the potential to improve the health of the population or special populations and reduce the need for or cost of health services.

RCW [43.70.575](#)

Definitions.

Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW [43.70.570](#) through [43.70.580](#).

(1) "Capacity" means actions that public health jurisdictions must do as part of ongoing daily operations to adequately protect and promote health and prevent disease, injury, and premature death. The public health improvement plan identifies capacity necessary for assessment, policy development, administration, prevention, including promotion and protection, and access and quality.

(2) "Department" means the department of health.

(3) "Local health jurisdiction" means the local health agency, either county or multicounty, operated by local government, with oversight and direction from a local board of health, that provides public health services throughout a defined geographic area.

(4) "Health outcomes" means long-term objectives that define optimal, measurable, future levels of health status, maximum acceptable levels of disease, injury, or dysfunction, or prevalence of risk factors in areas such as improving the rate of immunizations for infants and children to ninety percent and controlling and reducing the spread of tuberculosis and that are stated in the public health improvement plan.

(5) "Public health improvement plan," also known as the public health services improvement plan, means the public health services improvement plan established under RCW [43.70.520](#), developed by the department, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health services, and other state agencies, health services providers, and residents concerned about public health, to provide a detailed accounting of deficits in the core functions of assessment, policy development, and assurance of the current public health system, how additional public health funding would be used, and to describe the benefits expected from expanded expenditures.

(6) "Public health" means activities that society does collectively to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt, and counter threats to the public's health.

(7) "Public health system" means the department, the state board of health, and local health jurisdictions.

RCW 51.32.185

Occupations diseases—Presumptions of occupational disease for firefighters—Limitations—Exception—Rules.

(1) In the case of firefighters as defined in *RCW 41.26.030(4) (a), (b), and (c) who are covered under Title 51 RCW and firefighters, including supervisors, employed on a full-time, fully compensated basis as a firefighter of a private sector employer's fire department that includes over fifty such firefighters, there shall exist a prima facie presumption that: (a) Respiratory disease; (b) any heart problems, experienced within seventy-two hours of exposure to smoke, fumes, or toxic substances, or experienced within twenty-four hours of strenuous physical exertion due to firefighting activities; (c) cancer; and (d) infectious diseases are occupational diseases under RCW 51.08.140. This presumption of occupational disease may be rebutted by a preponderance of the evidence. Such evidence may include, but is not limited to, use of tobacco products, physical fitness and weight, lifestyle, hereditary factors, and exposure from other employment or nonemployment activities.

(2) The presumptions established in subsection (1) of this section shall be extended to an applicable member following termination of service for a period of three calendar months for each year of requisite service, but may not extend more than sixty months following the last date of employment.

(3) The presumption established in subsection (1)(c) of this section shall only apply to any active or former firefighter who has cancer that develops or manifests itself after the firefighter has served at least ten years and who was given a qualifying medical examination upon becoming a firefighter that showed no evidence of cancer. The presumption within subsection (1)(c) of this section shall only apply to prostate cancer diagnosed prior to the age of fifty, primary brain cancer, malignant melanoma, leukemia, non-Hodgkin's lymphoma, bladder cancer, ureter cancer, colorectal cancer, multiple myeloma, testicular cancer, and kidney cancer.

(4) The presumption established in subsection (1)(d) of this section shall be extended to any firefighter who has contracted any of the following infectious diseases: Human immunodeficiency virus/acquired immunodeficiency syndrome, all strains of hepatitis, meningococcal meningitis, or mycobacterium tuberculosis.

(5) Beginning July 1, 2003, this section does not apply to a firefighter who develops a heart or lung condition and who is a regular user of tobacco products or who has a history of tobacco use. The department, using existing medical research, shall define in rule the extent of tobacco use that shall exclude a firefighter from the provisions of this section.

(6) For purposes of this section, "firefighting activities" means fire suppression, fire prevention, emergency medical services, rescue operations, hazardous materials response, aircraft rescue, and training and other assigned duties related to emergency response.

(7)(a) When a determination involving the presumption established in this section is appealed to the board of industrial insurance appeals and the final decision allows the claim for benefits, the board of industrial insurance appeals shall order that all reasonable costs of the appeal, including attorney fees and witness fees, be paid to the firefighter or his or her beneficiary by the opposing party.

(b) When a determination involving the presumption established in this section is appealed to any court and the final decision allows the claim for benefits, the court shall order that all reasonable costs of the appeal, including attorney fees and witness fees, be paid to the firefighter or his or her beneficiary by the opposing party.

(c) When reasonable costs of the appeal must be paid by the department under this section in a state fund case, the costs shall be paid from the accident fund and charged to the costs of the claim.

Public Health and Safety

Control of Tuberculosis.

RCW [70.28.005](#)

Health officials, broad powers to protect public health.

- (1) Tuberculosis has been and continues to be a threat to the public's health in the state of Washington.
- (2) While it is important to respect the rights of individuals, the legitimate public interest in protecting the public health and welfare from the spread of a deadly infectious disease outweighs incidental curtailment of individual rights that may occur in implementing effective testing, treatment, and infection control strategies.
- (3) To protect the public's health, it is the intent of the legislature that local health officials provide culturally sensitive and medically appropriate early diagnosis, treatment, education, and follow-up to prevent tuberculosis. Further, it is imperative that public health officials and their staff have the necessary authority and discretion to take actions as are necessary to protect the health and welfare of the public, subject to the constitutional protection required under the federal and state constitutions. Nothing in this chapter shall be construed as in any way limiting the broad powers of health officials to act as necessary to protect the public health.

RCW [70.28.008](#)

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

- (1) "Department" means the department of health;
- (2) "Secretary" means the secretary of the department of health or his or her designee;
- (3) "Tuberculosis control" refers to the procedures administered in the counties for the control, prevention, and treatment of tuberculosis.

RCW [70.28.010](#)

Health care providers required to report cases.

All practicing health care providers in the state are hereby required to report to the local health department cases of every person having tuberculosis who has been attended by, or who has come under the observation of, the health care provider within one day thereof.

RCW [70.28.020](#)

Record of reports.

All local health departments in this state are hereby required to receive and keep a record, for a period of ten years from the date of the report, of the reports required by RCW [70.28.010](#) to be made to them; such records shall not be open to public inspection, but shall be submitted to the proper inspection of other local health departments and of the department of health alone, and such records shall not be published nor made public.

RCW 70.28.025

Secretary's administrative responsibility—Scope.

The secretary shall have responsibility for establishing standards for the control, prevention, and treatment of tuberculosis and hospitals approved to treat tuberculosis in the state operated under this chapter and chapter [70.30](#) RCW and for providing, either directly or through agreement, contract, or purchase, appropriate facilities and services for persons who are, or may be suffering from tuberculosis except as otherwise provided by RCW [70.30.061](#) or this section.

Under that responsibility, the secretary shall have the following powers and duties:

- (1) To develop and enter into such agreements, contracts, or purchase arrangements with counties and public and private agencies or institutions to provide for hospitalization, nursing home, or other appropriate facilities and services, including laboratory services, for persons who are or may be suffering from tuberculosis;
- (2) Adopt such rules as are necessary to assure effective patient care and treatment of tuberculosis.

RCW 70.28.031

Powers and duties of health officers.

Each health officer is hereby directed to use every available means to ascertain the existence of, and immediately to investigate, all reported or suspected cases of tuberculosis in the infectious stages within his or her jurisdiction and to ascertain the sources of such infections. In carrying out such investigations, each health officer is hereby invested with full powers of inspection, examination, treatment, and quarantine or isolation of all persons known to be infected with tuberculosis in an infectious stage or persons who have been previously diagnosed as having tuberculosis and who are under medical orders for treatment or periodic follow-up examinations and is hereby directed:

- (a) To make such examinations as are deemed necessary of persons reasonably suspected of having tuberculosis in an infectious stage and to isolate and treat or isolate, treat, and quarantine such persons, whenever deemed necessary for the protection of the public health.
- (b) To make such examinations as deemed necessary of persons who have been previously diagnosed as having tuberculosis and who are under medical orders for periodic follow-up examinations.
- (c) Follow local rules and regulations regarding examinations, treatment, quarantine, or isolation, and all rules, regulations, and orders of the state board and of the department in carrying out such examination, treatment, quarantine, or isolation.
- (d) Whenever the health officer shall determine on reasonable grounds that an examination or treatment of any person is necessary for the preservation and protection of the public health, he or she shall make an examination order in writing, setting forth the name of the person to be examined, the time and place of the examination, the treatment, and such other terms and conditions as may be necessary to protect the public health. Nothing contained in this subdivision shall be construed to prevent any person whom the health officer determines should have an examination or treatment for infectious tuberculosis from having such an examination or treatment made by a physician of his or her own choice who is licensed to practice osteopathic medicine and surgery under chapter [18.57](#) RCW or medicine and surgery under chapter [18.71](#) RCW under such terms and conditions as the health officer shall determine on reasonable grounds to be necessary to protect the public health.
- (e) Whenever the health officer shall determine that quarantine, treatment, or isolation in a particular case is necessary for the preservation and protection of the public health, he or she shall make an order to that effect in writing, setting forth the name of the person, the period of time during which the order shall remain effective, the place of treatment, isolation, or quarantine, and such other terms and

conditions as may be necessary to protect the public health.

(f) Upon the making of an examination, treatment, isolation, or quarantine order as provided in this section, a copy of such order shall be served upon the person named in such order.

(g) Upon the receipt of information that any examination, treatment, quarantine, or isolation order, made and served as herein provided, has been violated, the health officer shall advise the prosecuting attorney of the county in which such violation has occurred, in writing, and shall submit to such prosecuting attorney the information in his or her possession relating to the subject matter of such examination, treatment, isolation, or quarantine order, and of such violation or violations thereof.

(h) Any and all orders authorized under this section shall be made by the health officer or his or her tuberculosis control officer.

(i) Nothing in this chapter shall be construed to abridge the right of any person to rely exclusively on spiritual means alone through prayer to treat tuberculosis in accordance with the tenets and practice of any well-recognized church or religious denomination, nor shall anything in this chapter be deemed to prohibit a person who is inflicted with tuberculosis from being isolated or quarantined in a private place of his own choice, provided, it is approved by the local health officer, and all laws, rules and regulations governing control, sanitation, isolation, and quarantine are complied with.

RCW [70.28.032](#)

Due process standards for testing, treating, detaining—Reporting requirements—Training and scope for skin test administration.

(1) The state board of health shall adopt rules establishing the requirements for:

(a) Reporting confirmed or suspected cases of tuberculosis by health care providers and reporting of laboratory results consistent with tuberculosis by medical test sites;

(b) Due process standards for health officers exercising their authority to involuntarily detain, test, treat, or isolate persons with suspected or confirmed tuberculosis under RCW [70.28.031](#) and [70.05.070](#) that provide for release from any involuntary detention, testing, treatment, or isolation as soon as the health officer determines the patient no longer represents a risk to the public's health;

(c) Training of persons to perform tuberculosis skin testing and to administer tuberculosis medications.

(2) Notwithstanding any other provision of law, persons trained under subsection (1)(c) of this section may perform skin testing and administer medications if doing so as part of a program established by a state or local health officer to control tuberculosis.

RCW [70.28.033](#)

Treatment, isolation, or examination of health officer – Violation – Penalty.

Inasmuch as the order provided for by RCW [70.28.031](#) is for the protection of the public health, any person who, after service upon him or her of an order of a health officer directing his or her treatment, isolation, or examination as provided for in RCW [70.28.031](#), violates or fails to comply with the same or any provision thereof, is guilty of a misdemeanor, and, upon conviction thereof, in addition to any and all other penalties which may be imposed by law upon such conviction, may be ordered by the court confined until such order of such health officer shall have been fully complied with or terminated by such health officer, but not exceeding six months from the date of passing judgment upon such conviction: PROVIDED, That the court, upon suitable assurances that such order of such health officer will be complied with, may place any person convicted of a violation of such order of such health officer upon probation for a period not to exceed two years, upon condition that the said order of said health

officer be fully complied with: AND PROVIDED FURTHER, That upon any subsequent violation of such order of such health officer, such probation shall be terminated and confinement as herein provided ordered by the court.

RCW 70.28.035

Order of health officer—Refusal to obey—Application for superior court order.

In addition to the proceedings set forth in RCW 70.28.031, where a local health officer has reasonable cause to believe that an individual has tuberculosis as defined in the rules and regulations of the state board of health, and the individual refuses to obey the order of the local health officer to appear for an initial examination or a follow-up examination or an order for treatment, isolation, or quarantine, the health officer may apply to the superior court for an order requiring the individual to comply with the order of the local health officer.

RCW 70.28.037

Superior court order for confinement of individuals have active tuberculosis.

Where it has been determined after an examination as prescribed in this chapter that an individual has active tuberculosis, upon application to the superior court by the local health officer, the superior court shall order the sheriff to transport the individual to a designated facility for isolation, treatment, and care until such time as the local health officer or designee determines that the patient's condition is such that it is safe for the patient to be discharged from the facility.

Tuberculosis Hospitals, Facilities, and Funding.

RCW 70.30.015

Definitions.

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

- (1) "Department" means the department of health.
- (2) "Secretary" means the secretary of the department of health or his or her designee.
- (3) "Tuberculosis control" refers to the procedures administered in the counties for the control, prevention, and treatment of tuberculosis.

RCW 70.30.045

Expenditures for tuberculosis control directed—Standards—Payment for treatment.

Tuberculosis is a communicable disease and tuberculosis prevention, treatment, control, and follow up of known cases of tuberculosis are the basic steps in the control of this major health problem. In order to carry on such work effectively in accordance with the standards set by the secretary under RCW 70.28.025, the legislative authority of each county shall budget a sum to be used for the control of tuberculosis, including case finding, prevention, treatment, and follow up of known cases of tuberculosis. Under no circumstances should this section be construed to mean that the legislative

authority of each county shall budget sums to provide tuberculosis treatment when the patient has the ability to pay for the treatment. Each patient's ability to pay for the treatment shall be assessed by the local health department.

RCW 70.30.055

County budget for tuberculosis services.

In order to maintain adequate facilities and services for the residents of the state of Washington who are or may be suffering from tuberculosis and to assure their proper care, the legislative authority of each county shall budget annually a sum to provide such services in the county.

The funds may be retained by the county for operating its own services for the prevention and treatment of tuberculosis. None of the counties shall be required to make any payments to the state or any other agency from these funds except as authorized by the local health department. However, if the counties do not comply with the adopted standards of the department, the secretary shall take action to provide the required services and to charge the affected county directly for the provision of these services by the state.

RCW 70.30.061

Admissions to facility.

Any person residing in the state and needing treatment for tuberculosis may apply in person to the local health officer or to any licensed physician, advanced registered nurse practitioner, or licensed physician assistant for examination and if that health care provider has reasonable cause to believe that the person is suffering from tuberculosis in any form he or she may apply to the local health officer or designee for admission of the person to an appropriate facility for the care and treatment of tuberculosis.

RCW 70.30.081

Annual inspections.

All hospitals established or maintained for the treatment of persons suffering from tuberculosis shall be subject to annual inspection, or more frequently if required by federal law, by agents of the department of health, and the medical director shall admit such agents into every part of the facility and its buildings, and give them access on demand to all records, reports, books, papers, and accounts pertaining to the facility.

Hospital and Medical Facilities Survey and Construction Act.

RCW 70.40.020

Definitions.

As used in this chapter:

(1) "Secretary" means the secretary of the state department of health;

- (2) "The federal act" means Title VI of the public health service act, as amended, or as hereafter amended by congress;
- (3) "The surgeon general" means the surgeon general of the public health service of the United States;
- (4) "Hospital" includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, outpatient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals;
- (5) "Public health center" means a publicly owned facility for the provision of public health services, including related facilities such as laboratories, clinics, and administrative offices operated in connection with public health centers;
- (6) "Nonprofit hospital" and "nonprofit medical facility" means any hospital or medical facility owned and operated by a corporation or association, no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual;
- (7) "Medical facilities" means diagnostic or diagnostic and treatment centers, rehabilitation facilities and nursing homes as those terms are defined in the federal act.