

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

ATTACHMENT H



AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
RESIDENTIAL CARE SERVICES  
CERTIFIED COMMUNITY RESIDENTIAL SERVICES AND SUPPORTS (CCRSS)  
**CCRSS Home Environment and Safety Worksheet**

|                                     |                                     |
|-------------------------------------|-------------------------------------|
| CLIENT NAME AND/OR SAMPLE ID NUMBER | CLIENT NAME AND/OR SAMPLE ID NUMBER |
|-------------------------------------|-------------------------------------|

Check if multiple sample clients reside in the same home and observations were recorded with another sample client. Identify the other sample client(s):

|                      |                      |
|----------------------|----------------------|
| DATE OF OBSERVATIONS | TIME OF OBSERVATIONS |
|----------------------|----------------------|

**A. Quality of Life / Client Rights** WAC 388-101D-0170

| Y                        | N                        | N/A                      |  | Y                        | N                        | N/A                      |   |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was adaptive / life sustaining equipment available, clean, and in good repair? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was there accessible telephone equipment and list of emergency contact numbers (101D-0170)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were doors and windows unblocked (101D-0170)?                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were audio monitors used appropriately?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Door / window alarms?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was the environment homelike (101-3020,823-1095)?   |

**B. Physical Environment**

| Y                        | N                        | N/A                      |  | Y                        | N                        | N/A                      |  |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were stairs / steps, handrails / ramps, and walkways in good repair?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were flammable and combustible materials stored safely (101D-0170)?              |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Clear of clutter that could be potentially hazardous to the client(s)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was the yard free of garbage / refuse?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Was the property free of pests?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Were there clear signs of unsanitary home conditions (i.e., mold, mildew, etc.)? |

**C. Bathrooms**

| Y                        | N                        | N/A                      |                    | Y                        | N                        | N/A                      |                             |
|--------------------------|--------------------------|--------------------------|--------------------|--------------------------|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Safe and clean?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Accessible for all clients? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Adequate lighting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Private?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Grab bars?         |                          |                          |                          |                             |

**D. Safety**

| Y                        | N                        | N/A                      |  | Y                        | N                        | N/A                      |  |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Medications secured (101D-0330)?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Operating smoke detectors (with light alarm for clients with hearing impairments) (101D-0170)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | First aid supplies available (101D-0170)?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cleaning supplies / toxic materials locked-up if required by clients' safety needs?            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Working flashlight available (101D-0170)?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Evacuation plan and practice drills (101D-0520)?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restrictive procedures required by clients' safety needs.? |                          |                          |                          |  |

**Notes**

|   |  |
|---|--|
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| <b>E. Water Temperature: Check two locations (if either check is &gt;120°F, re-check locations over 120°F or indicate allowed by PCSP)</b>  |  |
| Kitchen Temperature: _____ °F<br>Time: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.  | Kitchen Temperature: _____ °F<br>Time: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.   |
| Bathroom Temperature: _____ °F<br>Time: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.<br>Additional location descriptor if needed:  | Bathroom Temperature: _____ °F<br>Time: _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.<br>Additional location descriptor if needed: |
| Is water temperature allowed >120° in PCSP? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| <b>F. Infection Prevention and Control (IPC)</b>  |  |
| Y   N   N/A   Observe staff are following and encouraging clients to follow standard precautions (select N/A for anything not observed).<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand hygiene (technique, before and after care, availability of alcohol-based hand rub or sink with soap and water)<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Appropriate staff use of PPE (gloves for bodily fluids and contact precautions, gowns, correct donning and doffing)<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Respiratory hygiene/cough etiquette (availability of tissues, trash, covering cough and sneezes)<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cleaning and disinfecting care equipment and environment (correct technique, timing, and appropriate product use)<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Safe injection practice (clean and disinfect designated area before piercing, new needle, syringe for containers)<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sharps safety (dedicated clearly labeled sharps container, container replaced before overfilling) |  |
| <b>For any observation marked “No” on the IPC section interview staff and, if possible, client.</b>   |  |
| Interview Date / Time / Name:   |  |
| What is your training?  |  |
| What is the reason standard precautions were not followed?  |  |
| What do you do to prevent the spread of infection?  |  |
| <b>G. Notes</b>   |  |
|   |  |