DSHS WASHINGTON STATE Department of Social and Health Services

Assisted Living Facility Resident Record Review

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

NAME	ID NO.	DATE OF BIRTH	ROOM NO.	MOVE-IN DATE	PAY STATUS

FAMILY / MEMBER / RESIDENT'S REPRESENTATIVE	REPRESENTATIVE'S PHONE	REASON FOR SAMPLE SELECTION

PERTINENT MEDICAL HISTORY / DIAGNOSIS

Yes	No	N/A	A. Assessment
☐	☐	☐	Pre-admission (for residents admitted in last six months, expand if needed).
☐	☐	☐	Full assessment completed with 14 days of admission (for residents admitted in last six months, expand if needed).
☐	☐	☐	Annual to meet resident's needs or semi-annual for EARC – Specialized Dementia Care contract.
☐	☐	☐	Updated as needed when there is a change of condition as defined in WAC 388-78A-2120.

NOTES

Yes	No	N/A	B. Monitoring Resident's Well-Being
☐	☐	☐	Documented.
☐	☐	☐	Action taken as needed.

NOTES

Yes	No	N/A	C. Negotiated Service Agreement (NSA)
☐	☐	☐	Initial on admission and completed within 30 days (for residents admitted in last six months).
☐	☐	☐	Updated as necessary.
☐	☐	☐	Contents meet resident's needs and preferences. • Signed annually by resident / resident representative, facility, and case manager (if applicable). • Defined roles and responsibilities of resident, staff, resident's representative, outside agency if used, and alternate plan when necessary. • Times services will be delivered including frequency and approximate time of day. • Resident's preferences for activities and how supported. • Identifies and incorporates Resident Arranged Services (if applicable). • Identifies and incorporates External Health Providers (if applicable).

NOTES

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Yes	No	N/A	D. Medication Services: ☐ Independent ☐ Assistance ☐ Administration
☐	☐	☐	Medication services provided by family (review plan).
☐	☐	☐	Medication services provided by facility (review plan).
☐	☐	☐	Appropriate for resident abilities and needs.
☐	☐	☐	Review of medication record.
☐	☐	☐	Documentation of refusal (if applicable).

NOTES

Yes	No	N/A	E. Intermittent Nursing Services Provided
☐	☐	☐	Nursing Service System developed.
☐	☐	☐	Services identified and appropriate.

NOTES

Yes	No	N/A	F. Modified / Therapeutic Diet
☐	☐	☐	Receiving Food Services as ordered.
☐	☐	☐	Receiving eating assistance.

NOTES

Additional Notes **Attachment J**