DSHS WASHINGTON STATE Department of Social and Health Services

HOME AND COMMUNITY LIVING ADMINISTRATION (HCLA)

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 (review all new residents in sample who have not yet received their first full annual assessment)
☐	☐	☐	Full assessment completed with 14 days of admission (review all new residents in sample who have not yet received their first full annual assessment)
☐	☐	☐	Annual to meet resident's needs or semi-annual for certified memory care residents
☐	☐	☐	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 / Rights
☐	☐	☐	Documented
☐	☐	☐	Action taken as needed
☐	☐	☐	Signed Medicaid policy acknowledgement (WAC 388-78A-2665)
☐	☐	☐	Signed Residency Agreement (Medicaid residents only)

NOTES

Yes	No	N/A	C. Negotiated Service Agreement (NSA)
☐	☐	☐	Initial on admission and completed within 30 days (review all new residents in the sample who have not yet received their first full annual assessment).
☐	☐	☐	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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ENTRANCE DATE	LICENSOR NAME

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**